PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE

PUBLIC MEETING

The Great Hall
The Hubert H. Humphrey Federal Building
200 Independence Avenue, SW
Washington, D.C. 20201

Tuesday, March 27, 2018
8:30 a.m.

COMMITTEE MEMBERS PRESENT:

JEFFREY W. BAILET, MD, Chair
ROBERT BERENSON, MD
PAUL N. CASALE, MD, MPH
TIM FERRIS, MD, MPH
HAROLD D. MILLER
ELIZABETH MITCHELL, Vice Chair
LEN M. NICHOLS, PhD
KAVITA PATEL, MD, MSHS
BRUCE STEINWALD, MBA
GRACE TERRELL, MD, MMM

STAFF PRESENT:
Nancy DeLew, Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Ann Page, Designated Federal Officer (DFO), ASPE
Mary Ellen Stahlman, ASPE
Sarah Selenich, ASPE

AGENDA PAGE

Avera Health: Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

PRT: Grace Terrell, MD, MMM (Lead), Harold Miller, and Kavita Patel, MD, MSHS

Staff Lead: Sarah Selenich

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P R O C E E D I N G S

[8:36 a.m.]

* **Opening Remarks by Chair Bailet**

CHAIR BAILET: Good morning. So this is the second day of the fourth PTAC public meeting, and we are going to start right in with reviewing the proposal submitted by Avera Health, Intensive Care Management in Skilled Nursing Facility Alternative Payment Model. Grace Terrell is --

DR. TERRELL: "Terrell."

CHAIR BAILET: Like I said, Terrell. Grace Terrell is the lead, Harold Miller and Kavita Patel. I've worked with her for a long time, but I was just making sure she was on top of her game this morning.

Avera Health: Intensive Care Management in Skilled Nursing Facility Alternative Payment Model

* **Committee Member Disclosures**

CHAIR BAILET: So what we're going to do as we start is we're going to go around the room and introduce ourselves and also declare any conflicts of interest potentially or impartiality, and I'll start with myself. Jeff Bailet, Executive Vice President of Blue Shield of California. I have nothing to disclose. Bob?

DR. BERENSON: Yes, I'm Bob Berenson. I'm an internist and a fellow at the Urban Institute, and I have nothing to disclose.

DR. PATEL: Kavita Patel, internist at Johns Hopkins and a fellow at the Brookings Institution. Nothing to disclose.

DR. NICHOLS: Len Nichols, a health economist at George Mason University, and I have nothing to disclose.

VICE CHAIR MITCHELL: Elizabeth Mitchell, President and CEO, Network for Regional Healthcare Improvement. Nothing to disclose.

MS. STAHLMAN: I'm Mary Ellen Stahlman, the ASPE staff lead for PTAC.

MS. PAGE: Ann Page, Designated Federal Officer for PTAC, which is a Federal Advisory Committee Act committee.

MR. STEINWALD: Bruce Steinwald, a health economist here in Washington, D.C. Nothing to disclose.

DR. CASALE: Paul Casale, Executive Director of NewYork Quality Care. Nothing to disclose.

MR. MILLER: I'm Harold Miller, the CEO of the Center for Healthcare Quality and Payment Reform, and I have no conflicts or disclosures.

DR. TERRELL: I'm Grace Terrell, at Wake Forest

Baptist Health. I'm a general internist and the Chief Executive Officer of Envision Genomics, and I have nothing to disclose.

DR. FERRIS: Tim Ferris, primary care internist at Mass. General Hospital. I'm the CEO of the Mass. General Physicians Organization. Nothing to disclose.

VICE CHAIR MITCHELL: And I skipped Sarah.

MS. SELENICH: I'm Sarah Selenich. I work in ASPE, and I helped support this Preliminary Review Team.

CHAIR BAILET: And I said it yesterday, but I think it warrants repeating. The staff that supports our Committee is phenomenal, starting with Mary Ellen, but Ann and Sarah and all the other folks who are behind the scenes helping this Committee maximize our potential. So, again, a real heartfelt thanks to you, Sarah, Ann, and Mary Ellen, and your team, and all the folks behind the scenes here who are making this happen. So we're greatly appreciative of that.

I'm going to go ahead and turn it over to Grace Terrell. Grace?

*** PRT Report to the Full PTAC**

DR. TERRELL: Good morning, and it's my privilege to lead the PRT team that consists of myself, Dr. Kavita Patel, and Harold Miller, who reviewed this proposal for

nursing home intensive management from Avera Health. I have nothing to disclose, but I do have something to say, which is I'm very excited to see those that are working with nursing home patients involved and being citizen patriots and coming up with things that's going to make our health care system better, particularly with this group of individuals that are so vulnerable and important in terms of the care that they receive in our system.

I started my first job in high school washing dishes in a nursing home. I've been the medical director of a nursing home. I've been on call for up to ten nursing homes at a time. So I was feeling this one personally. I know Dr. Patel also has experience taking care of nursing home patients. So we in particular had a PRT that understood the importance of this. Mr. Miller also expressed some of his own personal experience as a -- with family members in a nursing home. So thank you for doing this, and we're going to get into the details related to what the proposal ultimately said. I am not going to read it line by line, as was said yesterday.

So the name of it is the Intensive Care Management in Skilled Nursing Facility Alternative Payment Model, which I will not say correctly any more than our Chairman said "Dr. Terrell" correctly for the rest of the

time probably, as we tended to call it "the proposal from Avera Health," which is the name of the organization that did that.

So to basically review again how these presentations are done and what we do to get to the point of the public meeting, we have the PRT, which I introduced to you all, followed by an overview of the proposal, a summary of that. We're going to talk about the key issues, and then we're going to go through how we thought about each of the Secretary's criteria. And after that, there will be a time for the Committee to ask us questions for clarification. There will be the opportunity for you all to then come up, and we will ask you questions. You'll have a chance to speak, and if there's anybody in the public that wants to also participate in this.

So the role of the PRT is essentially to have members who will go into thorough detail of these reports to prepare the overall Committee, commission to look at it. We in our situation here, three members read, had several meetings about it. We interviewed the submitters. We also had a series of questions that went back and forth, and we also got data that we asked for in order to basically look at some of the analytics and the numbers behind things. And after that, we had at least three meetings, I believe,

after all of that for which we put together our thoughts in the report.

So this report is based on a Health Care Innovation HCIA-type of award Round 2 demonstration project that Avera Health had been part of. The goals of the model were to reduce avoidable emergency room visits and hospitalizations and lower the cost of care for patients that are both in skilled nursing facilities and nursing facilities.

There was a proposal that it be an alternative payment model and that the geriatric physician and practice would serve as the APM entity. And the services supported by the payments proposed would be geriatric care, geriatric-led care teams that would partner with SNFs and other nursing facilities, and supplement the facility's on-site services through telehealth.

In addition to the geriatrician, the submitter suggested that there could be other members of the team that would include geriatrics-trained support individuals, including advance practice providers, pharmacists, social workers, nurses, behavioral health, but there was a great degree of freedom within the proposal such that there could be choice made with respect to who was needed on the team.

The beneficiaries would continue to receive the

type of care they typically would from the nursing facility as well as a primary care physician. This would not supersede that, but would be a process in addition to that to improve the care. It would -- the type of services that would be rendered would be monitoring through telehealth the -- for the facility itself and the staff to have access to telehealth and also for the development of care plans, evidence-based disease management, advanced care planning, and the other types of things that it's asserted currently are not necessarily done with the ability to have geriatricians involved at all nursing facilities due to the shortage nationwide of that. It would also provide a 24/7 access to geriatricians, which is something that, again, is not common in current nursing homes very frequently across the country.

So the payment model, which was based, again, on the care model that had been fleshed out in their HCIA award, was two different options. Common to both of them was an up-front initial payment for the member, as well as a per member per month fee. So in both Option 1 and Option 2, that was there. There was no beneficiary cost sharing, and when we asked in detail whether this would be shared with the facility in any way, the answer was it would be up to the geriatric-led team, the APM, if that was to be the

case.

There were 11 performance measures, of which the APM entity could also monitor an additional 13 measures, and failure to meet standards on six of these would result is discontinued participation.

There were two options within the model. The first was essentially based on the per member per month as well as the up-front initial fee, and where there would be changes based on performance in year 3 if they did not meet four of the measures.

Option 2 was based on the ability to participate as a result of the MACRA legislation in an alternative payment model by also providing a payment model that would create some risk involved for the participants. So in this particular situation, there would be -- they would be eligible for shared savings beginning in year 1, risk for shared loss beginning in year 3. The savings would have a limit to 10 percent of the target amount. The losses would be limited to the new admission and per beneficiary -- per member per month amounts.

The actual Medicare Part A and Part B expenditures for all health care services rendered by the residents would be measured as well as 30 days post-discharge, and then beginning in year 3, the savings loss

would be adjusted based on performance measures with savings reduced for failure to meet four standards and losses reduced if standards not met on at least eight -- were met on eight.

So this won't take a whole lot of time to explain, but our Committee essentially looked at the ten criteria and, after a significant amount of discussion, felt were unanimous that they met the criterion on all ten of the Secretary's standards.

There were key issues that we identified. One of them is there's already some models out there that are really looking at this population of people that are in skilled nursing facilities and others, but that there is significant opportunity for improvement, and there is not necessarily models out there that are tied specifically to the types of payment models that they are proposing here.

The beneficiaries will receive 24/7 access to the geriatric-led care team through telehealth, and it seems like that will more than likely improve the quality and reduce the cost by avoiding emergency department visits and hospitalizations. So this sounds like something that will be very positive by basically hopefully providing care that would otherwise have someone go to the emergency room or to the hospital for evaluation.

We support the concepts that are in both of the payment models. We do believe that there are some nuances within some of the details of their payment methodology, which we can go into and I'm sure that we will talk about more as a commission here in a minute, that could improve it. And it was -- one of the other concerns is it was designed to work with a population of at least 5,000 beneficiaries, and there was comments in their proposal and in the questions when we asked them that they thought that it could work four smaller numbers of beneficiaries possibly in some more remote areas or rural communities. But much of that was not fleshed out, and it would certainly be something that would have to be thought through in great detail by CMS.

Our PRT felt that this, as we've had with other examples in the past, might have been a stronger proposal had there been simply a single model for payment because it makes a fair amount of complex -- fairly more complex to actually think through both of them and provide feedback. It, again, is one of those proposals that we have where we have to think about the imperative many people feel about coming up with a risk or a shared savings model to qualify as an advanced alternative payment model and whether that is influencing or not the way many of these payment models

were being proposed.

One thing was that the proposers said that the shared savings would allow for greater flexibility, but there was not much information provided as to how by virtue of having the risk in the shared savings it would allow for greater flexibility. That's something we may want to flesh out with them in more detail today.

Neither payment option proposed a way to risk-adjust with respect to emergency department visits, hospital admissions, or spending based on the specific type of patient characteristics. There are not necessarily a lot of good risk adjusters out there for nursing home populations, but because of the broad potential of this type of payment system, it seemed to the PRT that there might be an opportunity to think through how that could be done or should be done or whether it ought to be done.

And then one other significant issue was that it ties -- the model ties directly payments to quality health outcomes, indicators of health cost management, which is good. But it was a bit asymmetric with respect to the risk involved for not meeting those standards. And, in fact, you could potentially get payment even if it cost -- even if the cost went up based on some aspects of the model.

So I'm going to go through the ten criteria. The

first criteria is the scope. It's a high-priority criteria. The PRT felt that it met the criteria, that as I had previously said, there are existing models out there, but this certainly expands the options that are out there for this population within a potentially payment model. It also provides an explicit opportunity for geriatricians to participate in a payment model, which has not been out there in anything proposed currently, although the Committee did feel that this needed to be thought through as something that could be expanded into appropriately trained internists or family physicians who might also provide a lot of geriatric care.

It was designed to assume that the -- as I mentioned before, that it would serve a population of 5,000, but we do need to understand whether that would be feasible with smaller populations. And there was a lot of flexibility in the model. It's not real clear to the PRT how much of this depends on all of the units that are part of the model as opposed to part of them. So, for example, is telehealth an absolute necessity with this? Could the types of services be provided or the payment model be done in a different way? So these are some of the things that we felt needed to be explained in more detail.

With respect to the cost and quality, we felt

that the likelihood of 24/7 access to a geriatric-led care team would probably improve the quality and reduce the cost by unavoidable -- by avoidable ED visits and hospitalizations. There is data that we received from their work with the HCIA Round 2 award that some of that data was happening in real time as we were interacting with them that essentially shows that there is some positive return as a result of this. But we also saw that there are other areas of the country that -- where there is a much higher cost of nursing home care for which there may be even more potential than the particular region of the country where they're doing this type of work now, where the costs are already relatively low for nursing home facilities. So we thought that was positive.

The model will hopefully incentivize the care teams to partner with facilities where they perceive the most opportunity for -- based on patient characteristics since the one-time per member per month patients are not -- payments are not risk-adjusted, so we are concerned about the perennial issue of cherry-picking if this isn't thought through from that context. And there is -- needs to be a means for which we can make sure that appropriate hospital services are actually provided.

So with respect to the payment methodology, which

I described earlier, we support the fundamental concepts in both the up-front fee, the per member per month, as well as concepts of the shared savings and shared risk.

We do believe that the two-sided risk option incentivizes appropriately to reduce avoidable emergency department visits and hospitalizations.

There is, with a simpler payment design, less complexity but also less financial risk, which may allow greater participation from those that do not have this level of infrastructure or sophistication, but that in and of itself may have also some concerns that there would not be as much savings as a result of that.

The downside risk versus the upside shared savings is asymmetrical in the proposal, which we felt needed to be explored as to whether that actually creates the appropriate degree of incentives for the type of care that needs to be provided.

And, again, the lack of the ability to actually risk-adjust for ED visits and hospitalization admissions may create some perverse incentives that need to be thought through with the model if it's put in place by CMS.

More details of the payment methodology -- and we're going to spend more detail on this than some of the others because we really feel like the crux of this is in

what's been proposed here.

The performance measures would not impact payments in years one and two. The 11 measures include emergency department and readmission measures for the SNF patients but not for the nonskilled nursing facility patients.

And the performance measures do not negatively impact payments unless the alternative payment model entity fails to meet the standards on at least four measures under the shared savings option.

So, therefore, as I was mentioning earlier, it could fail to meet the standards for emergency department visits and readmission measures for skilled nursing facilities and not have an adverse performance adjustment.

And under the shared savings model performance factors only into the shares savings and loss payments and does not affect the monthly payments. So these are some nuances we need to understand the impact of better.

The simpler model option does not provide an increase in payments for good performance, which given its lack of complexity, there may be some limitations, therefore, to the flexibility of the type of services that could be innovated as a result of that payment model.

In terms of value over volume, we believe that it

met those criteria. The services are not -- the entity is not paid on a per-service basis but on a per-patient basis. So from that point of view, it would not necessarily perversely incentivize excessive services.

The entity is expected to risk-stratify patients to help deliver the right amount of care, but one of the points that need to be made -- and it's not their fault, but there is not a lot of good long-term data in terms of risk stratification on this population. So that may create some opportunity for CMS to actually work with this type of proposal to come up with ways where the risk adjustment could be improved.

The model provides for patients who are in skilled nursing facilities and nursing facilities far more flexibility in how the facilities can respond to the problems of the residents as opposed to just sending them to the ED where they get admitted to the hospital for things that could be managed there.

As I mentioned earlier, there is some discussion about flexibility being part of the shared savings but not a lot of details as to how that could be done.

The ability to be evaluated is something that we think also met the criteria because we can measure the numbers of emergency department visits as well as the cost

and the hospitalization.

The proposed measures are also things that are currently in other reporting programs and can be evaluated.

The ability to think through this with respect to severity adjustment, though, as we were just discussing, may be more complex as there are not currently risk methodologies that can do that.

We do believe there is the opportunity for improved integration and care coordination in this model by virtue of having the access to geriatricians and team-based care that have through telehealth improved the access across large populations in nursing homes, where that's not the case now.

It is very specific in the model that the primary care physician is still part of the team as the one who's responsible of the patient, but there is not actually explicit ways in the proposal how that integration and care coordination with the primary care would be guaranteed. So although there is a need to understand that this is providing the opportunity for integration and care coordination, it's not actually explicit about how that would be done or whether it absolutely must be done with what was proposed.

The model provides improved patient choice by

offering patients something besides going to the ED or hospital for care that would otherwise could be provided with the help of geriatric expertise and team-based care at the nursing facilities itself. There is also the option in the proposal for the patients to opt out of this if they didn't want to participate.

We did ask and cogitate a bit on what that would mean with respect to a nursing home facility if they are involved, with this proposal, if they have patients who are not willing to be in this, if that would actually disrupt process. We didn't believe that was an overall negative with respect to patient choice, but it may actually at the process level increase complexity at the level of delivering these services if it's not across the board at a nursing facility.

We believe that it makes -- the criteria of improving patient safety by virtue that there will now be 24/7 access to geriatric consultation, care, and expertise with the team in facilities that did not have that.

There is always, in any payment model, the potential incentive of patients who ought to appropriately be admitted to the hospital, not going to the hospital by virtue of the risk portion of the model here.

We do not believe that that was a strong enough

concern, that we did not think it meets criteria, but it ought to be thought through in terms, whether it's risk adjustment or audit or otherwise to make sure that patients who ought to stay at the facility stay at the facility, that those who ought to go to the hospital get there without there being incentives for them not to do that if it's appropriate to do so.

And, finally, with health information technology, telehealth in and of itself is integral to their proposal, and therefore, we believe that it meets the criteria on this, hands down.

One of the concerns we had is because nursing facilities were excluded from the original HITECH incentives for meaningful use and other parts of federal legislation that really pushed many other types of health care facilities into having electronic health records because part of their methodology is based on having access to electronic health records of patients, and not all nursing facilities have that right now in the U.S. They tend to be a little bit lagging behind the rest of the industry. That may actually decrease the likelihood that this could be scaled nationwide until the problem on that side of the issue with respect to the lack of electronic health records in all nursing facilities across the nation.

With that, the PRT submits to the entire Committee our recommendation that this, that it meets all 10 criteria for your consideration, and we're happy to answer questions.

CHAIR BAILET: Thank you, Grace.

Any other comments from the other PRT members before we --

DR. PATEL: Just one thing, that we did probe with the submitter kind of pluses or minuses of why this couldn't be done with just enhancements in the fee-for-service schedule or thinking about a more simple way to structure this. So we actually kind of went pretty deep into that, and that's in the transcription, but got a pretty good understanding of why there's a compelling argument, kind of speaking to No. 1 for scope for why there is a very compelling need for an actual APM in this setting.

MR. MILLER: I'll also just add there are two, I think, issues with this one that we're seeing with a number of applications. One is that, to some extent, there is a shared savings option here because of some feeling that there needs to be a shared savings option and not because it has been tailored precisely to this particular service.

So, as Grace mentioned, there were assertions

that there would be more flexibility under the shared savings model. The notion was that if you were accountable, then you wouldn't have to be so restricted in terms of exactly what services you deliver, but that really wasn't clearly articulated.

The other thing that I think is parallel here that we have seen now in a couple of cases is that it's a proposal brought to us by a fairly large organization that did it in a large -- or in a large setting. So Avera did this across a large number of sites and found that it was workable, and it's really useful to know that it works. It's not just a theoretical concept, but in fact, this kind of an approach works.

What we don't know is how extensible it is to smaller settings, and we saw that in the home hospitalization proposals, et cetera, is that there is a hope that it could be done that way.

But I think in this particular case, my opinion is there is no way to know that until you try it, and you can't try it if there's not a payment to be able to support it. So I think that to some extent, what we saw was something that was designed based on the way that the people who are doing it do it with the hope that it could be done by others the same way but without necessarily

experience to back that up, and I think the only way to find that would be through testing.

*** Clarifying Questions from PTAC to PRT**

CHAIR BAILET: Bruce.

MR. STEINWALD: Thanks for that good presentation.

So these are obviously all Medicare patients, but the Medicare SNF benefit is very limited. I wondered is there any sort of relationship between the model and Medicare SNF benefit or any of the patients eligible for the SNF benefit when they enter the model, or is it really just a population of the patients who reside in a nursing facility and happen to be also eligible for Medicare?

DR. TERRELL: I believe it's the latter.

The concept was how physicians would be paid who there are patients that are there that are on traditional Medicare, and that this is an additional service that could be provided as a payment model.

The piece of that as it relates to patients and their benefits was the concept that they would not have to pay for this in any sort of cost-sharing way that might be part of their traditional Medicare now.

MR. MILLER: So I think, just to be clear, the patients are Medicare patients, as Grace said, and they

could at any given point in time either be eligible for the Medicare SNF benefit or not, depending on whether they had been hospitalized recently.

The might have come in initially into a nursing home that way and then as they became -- sort of essentially became a long-term nursing facility patient, they might have been a nursing facility patient who then was hospitalized and qualified for SNF benefit. So at any point in time, there will be a mix.

CHAIR BAILET: Tim.

DR. FERRIS: Thanks for the PRT, and thanks to the submitters for working on this very important space.

I completely agree with you, Grace. A lot of my patients are in nursing homes.

I had a series of questions, and some of them are high level and some of them are sort of detailed technical, so I'll just try to get through them quickly.

The first questions relate to the performance measures, and I found the denominators for the performance measures odd. Like I wasn't prepared. They were facility-level patients in the facility level, and that was a -- I'm not sure how I would understand comparisons if the denominators at the facility level rather than the payment entity, the entity that is like all of your patients that

you have care for, rather than at the facility level, because of all kinds of interesting risk adjustment issues and so forth. So just the denominator had me a little scratching my head. I've never seen that before and didn't know how you were going to do benchmarking and so forth, and I just wondered if that came up in your PRT.

DR. PATEL: We did talk about it, and we actually then kind of opened Pandora's Box of how do we even with our like technical -- like our subcontractors try to even get -- and you'll see some of the conversation and the data that we tried to extract what that would look like on a more national representative population.

DR. FERRIS: Yeah.

DR. PATEL: And it's extremely difficult to do for all the reasons that SNF claims are problematic.

DR. FERRIS: Right.

DR. PATEL: So we were trying to approximate as best as we could the kind of literature scan on the data tables, but it was another aspect that was a limitation.

So that gets to, I think, Harold's kind of meta point of there were things that are very clear that this is -- Avera does just a great job at.

DR. FERRIS: Right.

DR. PATEL: And that's one of the areas that we

would say is probably --

DR. FERRIS: With the scale.

DR. PATEL: -- along with risk adjustment -- the scale issue, yeah.

MR. MILLER: Well, I'd add this model is -- and they can describe it themselves, obviously, but I think this model is sort of unique in the sense that it's partially a service to the patients. But it's partially a service to the facility.

DR. FERRIS: Right. Right, right.

MR. MILLER: And so the advantage of this structure -- because you're right it isn't typical in some ways, but in other ways, hospitals get measured based on what they do for everybody in the hospital, and the advantage --

DR. FERRIS: In that case, the hospital is the unit of payment. In this case, it's the facility is not the unit of payment.

MR. MILLER: No, I understand that. Right.

But the issue here is it also avoids the notion that it's based on the status that the patient happens to have at a particular point in time, back to this SNF nursing facility, et cetera, issue.

So you're absolutely right. I mean, it's

different. I think that given the nature of the service, to me it actually made more sense, in some ways, because they're trying to sort of help the facility. And the notion that it is a facility-wide service and they can't sort of say we're only doing this for a subset of patients that we happen to pick in a fashion that might be convenient had some advantages to it.

DR. TERRELL: And within that context, their point that it should be a facility-wide service, with the exception of somebody that opts out was a crucial component for why they thought it would work because they don't need to be -- a nurse in the middle of the night just doesn't need to be deciding is this one that can use this service or not.

DR. FERRIS: Right.

DR. TERRELL: So that to our mind made sense.

The other point in this is that because there's not that many measures that are out there, they all happen to be at the facility level, what is there? And so, therefore, what they're working with are the standards that are out there right now.

So that's -- again, I think they're starting from what they know and based on that have created payment models around it.

DR. FERRIS: I don't want to belabor this minor technical point, but it does make you wonder how you create thresholds then for performance if you have six different facilities, three perform well, two don't. How do you decide whether or not you're doing well or not? I'm sure there are ways you could do it, but it's novel.

The second thing --

MR. MILLER: Well, that was one of the concerns we had, that there's no sort of risk adjustment structure, and you can't tell whether you have a different population in one facility than the other. You're absolutely right.

DR. FERRIS: Right. Yeah.

And then the other one is among the measures, I didn't see -- there was only one measure that I was actually looking for, and I didn't find it, which is I don't think it's -- personally, I'll just make a strong statement here. I don't think it's acceptable to have a patient in a nursing home and not have an explicit documented goals of care, and I didn't -- I read through the stuff, and I didn't see a goals of care. I think that should be a requirement of any payment policy in that setting a la our discussions yesterday, and so I just -- did you guys -- was the goals of care issue raised?

DR. PATEL: We didn't raise it as explicitly as

you did. We got into it when we just -- it came up as part of our discussion around kind of tell us what your branded approach, so to speak, is to care for the geriatric patient and how you are coordinating that care with the patients' needs in mind as well as the primary caregiver and potentially primary care physicians and specialists network.

So the way you state it is a much more clear way, but we kind of got into it through their process, which --

DR. FERRIS: Yeah. I'm sure they do it so that it's probably they just didn't include it because they do it because --

DR. PATEL: I don't recall us calling it out as an explicit need.

DR. FERRIS: -- it's standard of care.

MR. MILLER: Again, this is an interesting model in the sense that it's not a nursing home payment model. It's a model for a support to the nursing home. So you'd say, "Well, so who is responsible for the goals of care? Is it the nursing home?" because this isn't affecting their payment for the nursing home.

DR. FERRIS: Yeah, but they're creating the medical plan. They're doing an intake like --

MR. MILLER: Yeah.

DR. FERRIS: They can't make decisions about what you're doing with the patient in a particular medical context --

MR. MILLER: Right.

DR. FERRIS: -- unless there are an explicit goals of care.

MR. MILLER: But I think we felt in general, the quality measures needed some work. We didn't think that in a sense that it was -- it was another one of those that they need some work, but it's not that it can't be fixed.

DR. FERRIS: Right.

MR. MILLER: It's just that the ones that are there right now don't feel to us like they're exactly the right ones.

DR. FERRIS: Okay. So the relationship with the PCP here was a little -- I'm again scratching my head over that one. So, you know, what they say they're doing in the plan of care, the creation of the plan of care, that seems like -- sort of a comprehensive plan of care seems like the PCP stuff, and they're providing 24/7 call coverage for acute issues. So I'm not sure what's left over for the PCP. And this is -- I think this is an important issue. Most patients that I know of in nursing homes, there is -- you're either the facility's doctor, or you are -- you have

your PCP, and the nurses call, you know, one way or the other. This is sort of an interesting hybrid where I didn't understand roles and responsibilities.

DR. TERRELL: We explored that in a fair amount of detail and discussed it among ourselves, but part of their model is they're working with what is there. There still needs to be a medical director in a nursing facility. There still needs to be PCPs that are there.

DR. FERRIS: Right.

DR. TERRELL: They could be hundreds or thousands of miles away since this is a telehealth process. So it may be more that we want to explore with them what their experience is doing this with PCPs, but we spent a lot of time actually thinking about that. Their responses, which are -- I believe you'll see there --

DR. FERRIS: Yeah, I read them.

DR. TERRELL: -- in the dialogue is that they did not want to be a disrupter of the traditional PCP relationship. So what is not in the model are explicit, I guess, requirements or -- as to how they will actually interact with the PCP. As we mentioned earlier in our comments, that it's about a collaborative relationship. So what you're getting at is how do you go from aspirational to something that involves a local person that's part of a

team with a geriatric support that's doing many of these other things. So that might be a good question to ask the --

DR. FERRIS: Yeah.

DR. PATEL: And I'll just add, Tim, that this -- we kept coming back around to thinking about scale beyond or even inside of this kind of model. I would say two things emerged: just the need for potentially simplifying the payment methodology; and then, number two, I would now add in the goals of a care plan into the same kind of consistency or responsibility for coordination and accountability of that coordination, because we even brought up, like, does this have to be a geriatrician, a board -- you know, potentially, and it does seem like this particular submitter makes a great case for it should be a geriatrician, knowing that that's not necessarily available in all facilities. But they also made a point to say that, like, within an hour they coordinate with a document usually by fax to the PCP, and that that's consistent and continuous.

So I think they have processes in place. We asked about metrics to kind of demonstrate that accountability. I think because they've been doing this within their, like, technology infrastructure, they're able

to do it within their facility. But there's not some, you know, NQF Measure No. 21 for documentation of goal of care and NQF Measure 23 for coordination with the PCP.

So I would strongly add that in as suggestions if this Committee moves forward to approve the model.

DR. FERRIS: Great. Just two more. So the -- I guess these are related. So the -- it seemed like two years was a really long time to get to performance. Like this is the kind of stuff where you, if you're on top of it and you're starting to treat UTIs instead of sending them to the ED, which is the most common reason for a transfer from a SNF to an ED, like, that should -- like, once you're providing the care, that should start happening right away. So one year would seem to me to be a generous period for getting to performance.

And related to that, this issue that you raised really struck me that the -- like, you did conclude that it met the value over volume and the payment methodology criteria, and yet you also pointed out that the -- you could actually fail on the ED and admissions since that is where the cost savings is, unless I'm missing something. I don't see how you can say -- please explain to me how those two things could be simultaneously true, that you could not include ED and admissions in the performance and guarantee

that you're actually, you know, reducing admissions. The fact that they were separable seemed to me to be, at least in Model 1, or the first -- the performance model, not the total cost of care, because it would be covered in the shared savings model. But I didn't -- I didn't understand how those two things could be simultaneously true.

DR. TERRELL: Because it's a fixed fee per patient, irrespective of the type of services provided. We felt that that is a type of payment model that will not necessarily entice excessive service. You're talking about the measurement of the actually performance of services that may or may not occur.

DR. FERRIS: Right, right.

DR. TERRELL: And that is what we did point out, is that those two things are both true, that they're not paid on the per service basis, which may, therefore, improve value over volume. But in the simplified model, they're also not held to performance standards for other services provided.

DR. FERRIS: So they're getting paid, but they're not necessarily delivering on the outcome that is the critical outcome.

DR. TERRELL: Well, other than over time, those numbers were adjusted in year 3, I believe, in the simple

one for performance and cost.

DR. FERRIS: But performance not necessarily including ED and admissions.

DR. TERRELL: Right.

DR. FERRIS: Which is the big performance issue that guarantee cost savings.

DR. TERRELL: Right.

DR. FERRIS: The other ones are all great, and I'm not -- I don't want to imply that I'm against any of this.

DR. PATEL: That's fair. I mean, I do -- I think we got into -- we did discuss the fact that you could still do very well and negatively perform to your point on those measures and felt like we -- the best way to say it is that we felt like if they did demonstrate on quality overall, that that was -- that that was not necessarily a problem. And that was another -- it was also related to the fact that we thought that having these two options were problematic, and that we would actually strongly consider a modification of blending of some kind, and that would actually take care of some of these issues.

DR. FERRIS: Great.

DR. PATEL: So, I don't know, Harold, do you -- I'm trying to --

MR. MILLER: Yeah, I mean, I -- this is, from perspective is you're absolutely right, but I guess the way I looked at it was the measures were there. You -- if you do badly on a whole bunch of things, you get penalized. It was only in this -- and so my attitude was I don't think that's good, but I think that's sort of fixable by a tweak, not something that you would say kind of the whole thing falls out because of that. And I think we all struggle with this sort of where is the point where it's sort of fundamentally bad, or where is it that the way they made the judgment about it we thought was a little short of where it should be? And at least my personal -- the way I came down was it was short of where it should be, but kind of the elements -- the elements are in here. They just need a lot of tweaking to be able to make --

DR. PATEL: And, Tim, something that was an undercurrent, and Grace mentioned it but I'll emphasize it, was that we didn't -- we were nervous also that there would potentially be such a pressure to not put people in the hospital when they needed it, so honestly, given the lack of data, the lack of understanding in this space, it felt like to me that we were okay with sliding on the ED admit side because we didn't want to create what we're seeing in current innovation models where it is, like, no, no going

to the ED. So in a way, we wanted to almost -- I hate to say this. It's almost like let this play out and understand the data better, because to your point, what we have is very limited understanding.

DR. FERRIS: Great. I'm sorry. I know I'm going on. I have one more.

CHAIR BAILET: Go ahead, Tim. And I had a comment to make specifically about this, but if you -- are you going to move on?

DR. FERRIS: Go ahead.

CHAIR BAILET: I guess when you're saying the data's not there, I think that these patients going to the emergency room and these patients getting admitted to the hospital are sort of the -- those two issues are the crux of what's driving quality and cost for these patients, that the issues are not being remedied at the home, and they're showing up in the ED, and they're showing up in the hospital. So I guess I'm -- the way I interpreted Tim's question, which was also on my mind, those are fundamental -- those are the fundamental reasons, not the only reasons but fundamental reasons to why you'd want to employ a model like this, to attack those two challenges for this population. And if I understand the mechanics right, you could do -- you could still perform economically well with

the measures and have -- and miss on those two. Is that --

DR. PATEL: In the first year [off microphone].

CHAIR BAILET: Technically.

MR. MILLER: I think I'd just -- maybe just reinforce what Kavita said. I think there is a real question about how to define whether they missed on these measures initially. This is not a well-benchmarked population, and given what they're trying to do, and we don't want to -- I would not want to penalize a facility that had already been figuring out the right way to do it, you know, again, by saying you didn't reduce or whatever, or had a particularly challenging population given the nature of what was going on in the community.

I mean, the other thing to think about with this, at least from my perspective, you know, I've seen this in a number of different rural communities that I've been working with, which Avera does a lot of work with, is there is a severe shortage of any kind of home care options in those communities, and you end up seeing, depending on the community, very, very different populations in the nursing home based on that. In some cases you may see patients who are much higher acuity in the nursing home because they can get lots of stuff in the home and others that you can't. And I don't think we're anywhere near being able to

understand kind of like whether a particular nursing home is doing well on that measure and whatever we get out of this. So that's more the issue. Again, I think the point is right. The question is I'm not sure that I would say, hey, applicant, go and come up with a better model right now because I don't -- I'm not sure that they could, when we talk about trying to extend this to the smaller -- to the smaller populations in different areas.

So that's the only thing, again, from my perspective, is I think the point is right. I don't think we should say somehow it's okay not to be worried about ED visits and hospitalizations, but to say we know exactly how to build that into a payment model, I'm not convinced that we do.

DR. TERRELL: One more point before you get to your next one is one of the Secretary's criteria -- access is not a criteria of the ten criteria that we're supposed to evaluate against. But I think there is an implicit value that sort of permeates a lot of the things that we think are important to value for care with respect to access in this model, where access to certain types of expertise in the middle of the night or whatever that's usually not there will in and of itself prevent certain types of behaviors and consequences for patients.

So to Harold's point, the data to measure that is hard to come by, but one of the things that this absolutely does is provide access to geriatric expertise 24/7 in remote locations that otherwise would not have that. So that in and of itself is a way of thinking about this even though we don't have the data yet, if you will, in terms of understanding -- if we believe that -- which I believe that the submitters believe and which I happen to believe that geriatric care adds value, having it for a population of primarily geriatric patients who are frail, elderly, and sick 24/7 as an access value ought to be able to demonstrate over time many of the things that we're not able to measure here.

DR. FERRIS: Great. No disagreement from me certainly on that, particularly around the care model issues and the lack of access.

My last question is actually sort of dollar and cents. So I just did some math around the PBPM and the 5,000 patients times a year. So it looks like the run rate per -- and I don't know what the unit is here. It's this $3.3 million annually to cover those 5,000 patients. And it seemed to me, on one hand, was that a big number, is that a small number? Well, it sort of depends on what the infrastructure is you're covering. If that's a

geriatrician, that's a really big number. If that's a geriatrician and a team and IT infrastructure, maybe it isn't. But did you probe the basis for the costs that were covered by that amount?

MR. MILLER: Yes. If you look at the transcript, you'll see my sort of colloquy with them about sort of what goes into the number and what number -- what number works. It's -- it is sort of -- I guess the rough summary of that was if you're going to have this whole team of people available, you may need that to be able to do that. The question, though, is if you're going to have that whole team of people, it's probably not enough if you're doing it at a smaller scale. So then the question becomes, okay, is that the right amount of money if you're doing it on a smaller scale and it's only supporting a geriatrician and is it okay to only have a geriatrician and not to have a whole complement of pharmacists and social workers and everything else available?

And that gets back to this it's just not clear right now what really -- we have one model supported by a HCIA award that says their particular model worked and this is what their model cost in their scale. And so the calculations I ran were sort of to answer the question, if, in fact, you had those levels of payment at a much smaller

scale, would it be enough to sort of support a basic kind of core element of sort of, you know, a geriatrician, and the answer to that seemed to be, yeah, it actually ends up being the right amount. What we don't know is, is that team too small to be able to achieve what they were able to achieve? Don't know yet.

DR. FERRIS: Yeah. There's an interesting and somewhat probably unique fixed cost/variable cost issues going on here.

DR. PATEL: And it might be good to have the submitters just give us the example that they kind of went through with us, because they did this down to a dollar. This is probably one of the most informed PBPM amounts I've seen just because they've got, like -- they're dealing with their fixed costs, and we did ask about, you know, for this GCT team, what's the ideal composition? And they were able to speak to that, which once again brings up the issue, could this be scaled beyond what they're doing? Maybe. But we don't know.

DR. FERRIS: So apologies to the Chair for taking up so much time, and thanks to the PRT for their excellent answers.

CHAIR BAILET: Apology accepted.

[Laughter.]

PARTICIPANT: What about to the rest of us?

[Laughter.]

CHAIR BAILET: Len.

DR. NICHOLS: So picking up on Tim's good line of questioning, I mean, you know, I'm an economist, so I know the data that I've dealt with, and I know deeply the flaws and claims and EHR and survey. But this SNF business -- so tell me again why we can't risk-adjust? I'd just assume that data's perfect if I haven't touched it. So tell me why we can't risk-adjust? What is it about -- we must have ICD-9s. We must have whether or not they were admitted in the last 12 months. We must have whether or not they went to the ED in the last 12 months. We must have something. How can it be impossible to risk-adjust?

DR. TERRELL: It's not that it can't be risk-adjusted. It just hasn't been done for this population. So if you look at --

DR. NICHOLS: Ever? I mean, there are a lot of people out there in AI doing prediction of low probability events that are doing exactly this.

DR. TERRELL: If you think about HCC coding or many of the type of claims-based coding, it was not built around a population of people in a SNF. It's not necessarily that you couldn't risk-adjust. It's just that

there's no standards related to it, and they didn't put risk adjustment in there.

DR. PATEL: And we agree with you, Len --

DR. NICHOLS: In the whole world?

DR. PATEL: And because it's going beyond the standard Medicare -- I mean, there were a number of issues beyond it's beyond the standard Medicare benefit potentially. We know those are people that have been --

DR. NICHOLS: Duals?

DR. PATEL: The duals thing wasn't as much of a problem as we thought it might be. But we would agree, and that's why it would be something that would strengthen this to actually --

DR. NICHOLS: So what I'm trying to get to --

DR. PATEL: -- propose risk adjustment.

DR. NICHOLS: -- are the data available? Or it has just not been done?

MR. MILLER: Well, it's not been done.

DR. NICHOLS: Okay.

MR. MILLER: I mean, I'll give you one quick semi-related analogy. Medicare has launched the entire comprehensive care for joint replacement model with no post-acute-care risk adjustment at all. So a patient who comes in for a hip replacement, some of them live alone and

are going to need to go to a skilled nursing facility, and some of them don't and are going to be able to go home. And there is absolutely no adjustment in that model for that.

Could it be done? Sure it could be done. But has it been done? It has not. And, you know, that requires linking information about post-acute care, functional status with hospital, and nobody's collecting the functional status sort of during the hospital stay, et cetera, right as afterwards.

Now, that's -- I mean, that's a somewhat different thing than this, but here's a situation where there are RUG scores for nursing homes that are intended to measure something about the level of resource need in the nursing home to take care of the patient, but nothing that says so what's their risk of having to be admitted to a hospital, go into an ED, et cetera? Same kind of a thing, right? So we have a system that's based on kind of the facility that they're in. We're not looking at the issue of the risk of them having some other thing afterwards. It can and should be built in, but right now the nursing home is not accountable for how many ED visits it has, so nobody's figured that out.

So that was the point, again, I think back to

this issue of should it be there? Yes. Is it reasonable to expect the applicant to have developed that before they bring us a model? Ehh, I -- you know.

DR. NICHOLS: I concur. Okay.

So, Tim, that may be one reason why two years is not such a bad plan.

Okay. Second question. On the quality target business, especially the thing about if you satisfy more than eight or whatever, so you don't have to satisfy ED and hospital, why not wait those 11 things in a way that makes more sense? Doesn't that seem obvious?

DR. TERRELL: Why don't you ask them?

DR. NICHOLS: Okay, fine.

And then I was really intrigued at the two model, if you will, here you pick and you all really didn't pick. You just sort of said, well, you might ought to have a hybrid.

So what do you really think? Should we have one, or should we remake this?

DR. TERRELL: This is not the first model that we've been presented this with now as a PTAC, and we did not pick because we don't think that that was our role. We looked at both of them.

DR. NICHOLS: As a PRT.

DR. TERRELL: Yeah. That's right.

We looked at both of the aspects, commented, made analysis of both aspects, what the weaknesses and strengths were, but this -- maybe as we're having our broader discussion about this today, we can start deciding as a PTAC how to address this issue, or maybe we can start in our commentary saying it's actually making it more difficult.

We put in our report that had it been simpler, it would have possibly been stronger, but that's all we did. We did not pick.

MR. MILLER: I think the other issue is what came up in the discussion yesterday, is I'm not sure there is one model for everybody, and the notion that we could pick one and say it's better when you'd say, gee, the first model really might be the only thing that could work for somebody who's trying to do this with a few small rural facilities and the other model -- again, I'm not saying it's these models, but there might be a different model that had different resources, different accountability for somebody who could do it on a bigger scale with different kind of resources.

And right now, we don't know which of the delivery models is better and whether they could -- any one

delivery model could work in multiple places.

I would be reluctant to have us say we pick one as opposed to saying we need some better information as to which of these models might work in different settings to determine whether or not two are needed or not, and we don't really have enough information right now even to make that judgment, I don't think.

DR. NICHOLS: Well, I would agree with you, Harold, which is why I was -- I mean, the applicant said they wanted PTAC to pick. I would say I'd rather try them both and let people out there in the field choose which one to test and so forth.

MR. MILLER: But I think the "you pick" was more of a -- this common problem is nobody knows what Medicare will approve, and so they have two different models, and they think that, "We're Medicare, and so we can pick one." And that ain't true either.

DR. PATEL: Plus, the A-APM, I mean, they didn't try to -- just to be clear, they did not invoke that in their proposal, but it's clear to me that there's a lot of this like flavor of, oh, if we put in shared risk, then that will qualify them for an A-APM, and so we didn't feel like that -- that was another reason it was just too hard to say, "No. Away with option No. 2."

CHAIR BAILET: Bob.

DR. BERENSON: Well, the PRT did a great job of asking all the questions I could possibly think of.

I'm going to probe just a couple of them because I wasn't quite satisfied with the answers, and I wanted to get some sense of the PRT. I'll mostly be asking them.

Tim has raised the one. I just want to pile on a little bit. It is this diffusion of responsibility between the PCP and the entity, the geriatrician entity that's taking risks, so it's related to the shared savings thing.

I think they're trying to have it both ways. The question here is, How does the model guard against patients being kept out of the hospital inappropriately? And the answer is the PCP remains the party ultimately responsible for coordinating care, and it has no monetary incentive to inappropriately keep patients out of the hospital. So they would be the protection for the patient. I don't know how that happens at two in the morning when the patient spikes a fever and is coughing. I don't see how the entity that has the shared savings incentive is different from the primary physician who is responsible for the patient.

So I'll be pursuing that. Does the PRT have anything more to say on this one?

DR. TERRELL: Well, as I told you earlier, I had

copious experience, being the primary care physician who is called in the middle of the night, and so as I was reading this proposal and hearing their answers, I was thinking about the actual logistics of what would likely occur.

And my thought process was that it -- and we can, as you said, explore this in more detail. There's a lot of calls that happen now, usually at three o'clock in the morning, where a patient is found to have some event that the nurse calls a physician on the phone, who is typically a physician who doesn't know the patient because it's statistically in a call group. It's going to be more than one person. So the default is always go to the ED because there is no likelihood that that's going to -- anything else is going to be the right answer when you don't know the patient in the middle of the night and you don't have a lot of access to things.

If there is now inserted in that process -- this is the way I'm thinking about it -- a team that actually 24/7 knows the patient through electronic means or otherwise has access to the care plan and otherwise who's involved at that level and they are called first, there may well be information that is part of that process that will allow other things to be done besides an emergency default call in the middle of the night.

But just like now, if I were on call for a primary care physician and the next day, they get the call or they are looking at things and they're basically saying, well, jeepers, this person has this or that, we ought to be doing this or that, the ultimate care is the responsibility of that person, the way our system is set up.

I think what this does is actually for the other four out of five nights that the person who is on call is actually out there, that this is just a different or better level of service information, care planning, and all that. Now, that's my thought process about it, just as somebody who has experienced it.

I think back to the days when I used to be on call for the ED and had to be the one that actually went in after I told them to go to the ED, and I was on call for eight nursing homes at a time. And that particular system is just terrible, and that's still where it is in a lot of the country right now.

So had I had this service back then, I would have probably stayed in the nursing home business a whole lot longer.

DR. BERENSON: But it does suggest --

MR. MILLER: I think --

DR. BERENSON: Let me just respond there.

DR. TERRELL: Yeah.

DR. BERENSON: A real need for end-of-life planning coordination between the PCP can simply be, hey, you get a call at two in the morning. You're the geriatrician who is staffing the office that night. That all has to have happened and to be continuously updated. I mean, it's a real effort to pull that off.

DR. TERRELL: I agree.

DR. BERENSON: Okay.

MR. MILLER: I think one of the weaknesses that we saw in the proposal was it wasn't quite clear that there was a clear connection to the patient's preferences.

But I think to the question that you asked, to me the answer that I guess I found convincing was they're there at the invitation of the facility and the medical director, et cetera, and if they all of a sudden start saying don't send the patient to the hospital and bad things happen, the invitation will be withdrawn. So it might not happen at the individual patient level for the first couple, but then it would be stopped.

DR. BERENSON: And that's a good point. To me, it's another suggestion that shared savings is not an appropriate approach for this population.

DR. TERRELL: One other issue that this is sort

of related to is the point that I made -- or that we made in our report that you can't tell how much of the elements itself is actually crucial for the actual model of care and payment. So there's data out there now that facilities who employ a nurse practitioner or a PA during the day as part of the facility have better outcomes than those that don't have them that simply rely on primary care.

It may be the same phenomenon without 24/7 access and that you've got somebody right there as opposed to some doc in down who she's trying to see her regular patients or somebody is rounding periodically.

They have developed a particular care model that appears to work through telehealth and improves access to places. They have put a payment model around it that we're looking at right now, which is, I think, crucial. But the very components of the various things in terms of what's crucial in all of it together is not clear to me.

DR. BERENSON: Mm-hmm. Okay.

The second area is -- and you made a little brief remark that you wound up being satisfied -- about the duals issue. Medicaid and Medicare having completely conflicting incentives and cost shifting, I mean, there's a whole duals office at CMS somewhere up there. There have been demos. Two of them are fee-for-service demos.

Evercare has been around for over two decades. It works, and yet it's not widely adopted anywhere. I'm not exactly sure why, but I suspect it's because there's this fundamental Medicaid incentive to send patients to the hospital, not only because you can hold the bed and not have the cost of the care, but to get the three-day stay to then have the patient come back as a SNF patient.

In the HCIA -- I guess this is the way to ask the question. In the HCIA award, is this not a problem? I mean, in the results, they are able to sort of -- their response to the question when you asked them was, "Well, we're not making it worse," and then they had some mitigating factors.

But the question is "Can this model work unless you actually do the financial alignment?" is the question I have, and is there any instructions from their HCIA experience that would help us know that this is worth doing, even if we don't get those financial alignments, or that they should happen in certain states that are making a commitment to work through those issues? That's my question.

VICE CHAIR MITCHELL: And I'd just like to pile on because one of the things I noted in the Q&A was that the resistance seems to be from the local hospitals, which

isn't terribly surprising. So the scalability, if there is not a receptive community, is one of my questions.

DR. BERENSON: Yeah. I was going to ask. The demo happens, and maybe nursing homes don't want to participate. I mean, you're emphasizing that hospital. How do we know that there's actually going to be receptivity to bring this team in?

DR. TERRELL: Well, the receptivity, they've got experience with themselves. So we did ask that, you know, what types of -- and one of their answers was it -- at the facility level when somebody -- where they started this initially, the services were not used. Before it was over with, they were just absolutely completely part of their process and all that at the per-unit nursing facility level.

What you're saying is, Well, what about these others that are out there that didn't want it, never involved? Can you look at the two? Were the incentives different in terms of all the issues around the dual eligibles and all of that? And that will be worth exploring with them. But I do believe their model has to be based upon receptivity.

I suspect, from my personal experience, that many communities are not served by the current primary care-

dependent model or medical director-dependent model, and that for many, this would be a solution to many problems that they don't have. But it would be something well worth exploring in more detail with them.

DR. BERENSON: Okay. That's all.

CHAIR BAILET: Thanks, Bob, and thanks to the Committee for detailed exploration. And I think that, frankly, we set the table for the submitters to come on up to the table because there were a lot of questions that I think are best delivered to them.

So, as you sit down, turn your placards over. That would be great. You have 10 minutes to address the Committee. Starting, it would be nice if you guys could introduce yourselves just for the folks following on the phone as well.

Welcome.

*** Submitters Statement, Questions and Answers, and Discussion with PTAC**

DR. BASEL: Good morning. So I'm David Basel. I'm an internal medicine, pediatrics, and clinical informatics physician. I'm vice president of Clinical Quality for Avera Medical Group, and I was the principal investigator for the HCIA clinical delivery model in which this payment model is based.

To my left?

DR. REES: I'm Joseph Rees. I'm one of the geriatricians in the model, and I am the chief medical officer currently for the eCARE senior care program.

MS. LARSON: Good morning. I'm Deanna Larson. I'm the CEO and president of Avera eCARE. I'm also a nurse and administrator by background, and I'm the daughter of an elder who received care in a skilled nursing facility that I had a vision it really could have been better.

So I want to express my gratitude to the team here who is with me who helped that vision become a reality and also to the Committee here who's taken so much time to prepare and have audience with us today.

MR. HOFMEYER: Good morning. I am Josh Hofmeyer. I am a licensed nursing home administrator and the senior care officer at Avera eCARE, responsible for overseeing the CMMI award that we had and then growing it into the model that we offer today.

MS. BELL: And good morning. I'm Mandy Bell. I'm the eCARE quality and innovation officer, so I work with lots of different telehealth services. This one has a special place. It's a project I've been working on since 2011.

DR. BASEL: So, Chairperson Bailet and honorable

members of the PTAC, thank you for the opportunity to present our intensive care management and skilled nursing facilities alternative payment model. I have a hard time saying this one as well. We should have come up with a better acronym, I admit. All right.

We especially want to thank the members of our Preliminary Review Team: Dr. Terrell, Mr. Miller, Dr. Patel. We really appreciate your time and commitment that you put in reviewing this proposal and the discussions with you. I think that this model is stronger because of that commitment of time.

When we started on this journey, we recognized that the post-acute space was a significant and underrepresented area for opportunity and driving towards the National Quality Strategy -- better care, healthier people in communities, and affordable care.

Current post-acute models allow many beneficiaries to fall through the gaps in the system, resulting potentially preventable emergency room visits and hospital admissions. These preventable transfers and subsequent admissions cost CMS an estimated $4 billion per year.

Through our own experience in reviewing the literature, we felt that there were three interrelated

challenges to high-quality care for these residents: number one, limited access to timely physician care for high-risk residents; number two, a shortage of geriatricians to meet the needs of a growing population of elderly Americans; and number three, skill gaps in the capabilities of nursing home staff to address the increasing acuity of these residents.

There is also a growing body of evidence that shows that a multidisciplinary team-based approach in nursing facilities can help address these issues. Most notably, the CMMI initiative to reduce avoidable hospitalizations among nursing home residents has shown very promising results in a wide spectrum of these type of interventions. This evaluation has mirrored other evidence that has shown the most effective combination is having improved quality and performance improvement processes and facilities as well as increased on-site access to higher-skilled geriatric trained providers.

However, when we looked at trying to implement this type of model, we found it to be very resource intensive and cost prohibitive. Therefore, we thought to incorporate our expertise in telemedicine to help reduce the cost of delivering this type of care model as well as to expand the scalability beyond those localized areas that

already have ready access to skilled geriatric in-person providers.

At Avera, we have a strong history of successfully utilizing telemedicine to help address the challenges of providing high-quality, cost-effective health care in rural America.

We have successfully developed and deployed diverse programs such as ICU e-counsel, e-pharmacy, e-emergency, and others in over 300 locations across 16 states. In fact, over 13 percent of all critical access hospitals in the United States have at least one of our telemedicine programs to benefit them.

The e-long-term care program has grown out of a similar response where we have noticed a local need and then scaled up regionally to reach economies of scale. Specifically, e-long-term care was intended to leverage a scarcity of geriatricians and geriatric-trained pharmacists, behavioral health specialists, RNs, and social workers in a cost-effective manner.

Our care delivery model was developed first underneath the HRSA grant and then subsequently was funded underneath the CMMI Health Care Innovation Round Two awards.

So far, we have implemented this model

successfully in over 65 facilities across five states serving over 12,000 residents.

While official CMMI evaluation of Round Two HCIA projects is not expected for another year, internal evaluation of claims data has shown a $342 per beneficiary per month reduction in Medicare's total cost of care. Moreover, the telemedicine component has kept the overall program costs much lower than in in-person models.

Additionally, as stated in the PRT review, this model was carried out in a relatively lower-cost area of the country. So part of the nations that have higher cost could see even larger impacts on total cost of care.

Next, I want to pull out some key aspects of this program that have led to its success. First, 24/7 access to multidisciplinary geriatric care team overcomes many of the barriers present today in the nursing facility setting. Specifically, it helps overcome the difficulty nursing facility staffs frequently face trying to get PCP's attention during busy clinic hours, both urban and rural, let alone after hours or on weekends.

However, this model is not nearly the use of telemedicine to provide 24/7 urgent care access, but rather the universal care transformation and performance improvement initiative delivered via telemedicine, and

that's an important distinction. This is not just urgent care telemedicine. This is a complete facility-wide transformation.

Our intent is to help change the culture from a reactive culture where problems frequently are allowed to fester until they reach an advanced stage to a proactive culture that identifies health care concerns when they are still preventable and treatable; for example, catching symptoms at the stage of a cough rather than several days later when they're septic from pneumonia.

Another example of this proactive approach is our emphasis on care coordination, especially during transitions of care, into the nursing facility and back out into community, when applicable. It is during these critical transition times that traditional processes often fail, especially around medication reconciliation, optimization, and chronic disease management.

Our proposed model provides incentives for the geriatric care team to help empower and support the local nursing facility teams in their performance recruitment efforts, along with helping to increase their knowledge and skill sets. For example, if we see a trend of increasing admissions for lower extremity cellulitis, we would conduct education around early recognition, both during individual

virtual visits, one-on-one, as well as offering asynchronous and continuing nurse education on the topic, and we'd also support the quality assurance and performance improvement activities on that topic at the local site.

As you stated before, this model is not intended to replace the PCP-to-resident relationship. We feel that is critically important. Instead, we seek to augment access and fill in gaps of care. This retention of PCP oversight is an important component that helps ensure that quality doesn't suffer or lead to stinting of care.

From a payment model perspective, our proposal is designed to balance three major themes: accountability, flexibility, and simplicity. Many of the questions and concerns that have been brought up this far, and I suspect we're going to discuss in further detail, stem from the tradeoffs inherent between these three themes.

First off, accountability. This concept is key to enabling the other two themes of flexibility and simplicity, and important, you know, in adoption. This is why we chose to go through the APM development track rather than the more traditional track petitioning CMS to open up fee-for-service fee schedule through the annual fee schedule update. We chose to include both a core set of financial and quality outcome metrics for which we felt had

a direct impact on, but also include a secondary monitoring set of existing quality metrics to help ensure that an unintended decrease in care didn't occur.

Second, simplicity. In our opinion, the more simple the model, both for CMS and for proprietors, the higher the model adoption rate that could be achieved. Thus, whenever possible, the model builds off existing structures and processes. For example, when choosing quality metrics, instead of creating new, highly tailored metrics, the model utilizes existing nursing facility value-based metrics that have already been validated and for which good benchmark data already exists.

Third, flexibility. We initially considered proposing a model that very rigorously followed our HCIA care delivery model, including detailed specific requirements around required team members and procedures. Indeed, if we were going down that traditional fee-for-service code set route, we think that would be an imperative. However, by including the accountability piece, that helps reduce the amount of regulations and specificity that has to be placed on the structure of the model. This opens up the care delivery model to a lot larger group of clinicians and team design and innovation.

This is also why we chose to include two

competing payment models, giving PTAC and CMS the option of placing the higher priority either on flexibility or on accountability. The performance-based payment model has a lower degree of accountability but would allow smaller practices to be able to implement, whereas the shared saving model, with a greater accountability, would likely limit entry to generally larger entities but potentially increase the likelihood of achieving the desired outcomes.

So, to summarize, this model goes beyond only establishing 24/7 access via telemedicine, which alone can be significant, that also develops and establishes widespread support to overall performance improvement, care transformation, and moving the nursing facility staff paradigm away from fragmented care.

From the nursing facility standpoint, the local team feels empowered and better supported with this 24/7 guaranteed access to a team of responsive specialists. From a PCP standpoint, the geriatric care team relieves much of the day-to-day burden of managing unexpected complications and tasks while helping to maintain that critical PCP-resident relationship. From a nursing facility resident perspective, this program has been well received, due to the ability both to increase access and timely responses as well as preventing unneeded and, in

most instances, unwanted transfers.

Thank you again for the opportunity to present our proposal, and we look forward to answering your questions.

CHAIR BAILET: Thank you, and I open it up to Committee questions. Tim.

DR. FERRIS: Okay. Well, you've already heard all my questions, which is why I asked them so that you had some time to prepare. So, also, thank you, from me. I know you've already been thanked multiple times. I'm sure that will continue to happen over the course of this.

The space you're working in, as you pointed out, I fully agree it is a huge need. My father is in a nursing home now. My mother died in a nursing home two years ago. And I would say the services that are provided -- let's just say that as a physician and a son, I provide the bulk of services to my father, and have no idea how people who don't have a child who is a physician or a nurse navigate that.

So let me just ask, and I'll ask it in a way to make it so you don't have to give, hopefully, long answers, but on the question I asked about inclusion of the ED and admission rates as a -- would it be incompatible with your model to actually include that as a mandatory performance

issue rather than sort of as one of a number. Just getting to this specific issue of how do you -- and I love the way you framed it, the accountability issue. So I'm going after accountability in your simpler model, and trying to increase accountability in your simpler model, focused on that specific issue.

Do you see a world in which you could do that?

DR. BASEL: That also kind of goes -- I don't remember if it was your suggestion or somebody else's, about perhaps weighting certain metrics a little bit higher than others. And we did consider that a little bit, and a couple of different reasons. We worried, one, if we did weight those and put too much emphasis on just those costs and readmission numbers that then we would be getting more pushback on this side about too high of an incentive to keep people out of the hospital. And so we tried to take a little bit more of a balanced approach to avoid that concern.

The other thing around that is we feel pretty strongly -- and I think there's evidence out there that shows correlation between the nursing home star rating and readmission rate, in general. You really -- it's very hard to unpack these things. Every system is perfectly designed to the results that it gets, type of thing. And if it's a

high-quality nursing home it's likely to have high quality and low admissions rates, and it's pretty hard to uncouple those two, in our opinion. Certainly we would not be adverse, you know, if CMS or PTAC felt strongly about reweighting those a little bit higher, but practically I think they're going to go hand in hand, for the most part.

DR. FERRIS: There are solutions. You know, if you're already a good performer, there's -- actually, most of the CMS measures have an improvement or attainment model. So if you've already attained it from the beginning then you're in. So there are fairly simple solutions, right?

DR. BASEL: And we actually did include both raw attainment as well as improvement solutions. And getting down in the weeds a little bit, but it sounds like you like to get in the weeds, so we'll go there.

[Laughter.]

DR. BASEL: We did --

DR. FERRIS: Guilty.

DR. BASEL: -- we did look at that improvement model pretty closely, because these are all Nursing Home Compare or Nursing Home Value-Based Purchasing metrics that we chose, and we specifically chose them because they were, because they had those data sets, those benchmarks already

established. But when we went to the improvement calculations we got a lot looser --

DR. FERRIS: Mm-hmm.

DR. BASEL: -- a lot more generous on the improvement calculation than they did in there. Because if you think about, let's say where do you want this program the most, you probably want it in that lower decile performance. And so if you look at the way that improvement points are counted right now in nursing homes, it might get you from 0 points to 20 points out of 100, but you're still going to be well below average, and we'd still have a huge disincentive to go into there, if we say either, you know, those improvement points or something have to get you above 50. You know, we never want to go into those lowest decile ones unless we get pretty generous with how we score those improvement points. And so we did think about that very carefully.

Because the nursing facility itself is still going to take the hit, as they probably should for having low quality, but want to be benefitted for helping get them up at least closer to where they need to be, and year after year after year they'll get there.

DR. FERRIS: Great. And then the second question I had was around the goals of care issue that raised, so

it's not in the quality measures. I fully expect it is an essential part of what it is you do, because I can't actually imagine responding at 3 in the morning on a 24/7 access without actually knowing what the goals of care are. So why wouldn't that be -- is there a problem with making that a requirement?

DR. BASEL: So again, this goes back to overall philosophy that we had regarding how much specificity to put into this. And if this was a fee-for-service code set we would have submitted an incredibly rigorous set of thou shalt do this, have these members of the team doing this on this type of a schedule and stuff. Because of that accountability access, we kind of backed off into more, you should have a strategy for the following things, and your team should have the skill set of the following things, so that allows a broader degree of things.

And if you look at the requirements that we did put in there, things like advanced care planning, that type of stuff are mentioned in there, and certainly part of what we do. And if you don't do those I fully agree with you, you're not going to meet the goals of this program and you're not going to be able to be billing for this after a certain level of time. And so that's absolutely.

The other thing about that, we considered

putting, you know, very structured processes around advanced care planning, around integration and care coordination, and some of these sorts of things. You know, there's tools like INTERACT out there and we're certainly -- our team is INTERACT certified. And rather than taking a very strict view of enforcing this particular strategy in every single nursing home we go into -- because some of our nursing homes are very advanced in INTERACT tools and love them. Other facilities we go into have tried them and say, "You know, this is way too burdensome. We don't get the point." Others are using a competing type of thing.

What we care about is, you know, kind of similar to patient care thing. You start with meeting a patient where they are. Sometimes the patient's worst idea is better than your best idea, because they're actually going to implement it. Same thing. Sometimes the nursing home's worst idea is better than your best idea, because they're actually going to implement it. So meeting them where they are in their quality and performance improvement strategy and moving them along that continuum, rather than trying to enforce a rigid set of requirements on them, is what they did.

But maybe, you know, Dr. Rees, if I can maybe ask you, kind of, maybe giving an example, a story sometimes is

worth 1,000 of my logical points, so maybe hit that a little bit.

DR. REES: Well, I think I want to piggyback on that idea just a little bit. One of the things that we have access to in the facilities that we are in is their medical record. So most nursing homes that we have been in we have found actually do have some type of electronic medical record, and most of those have a location for their advanced care planning and patient-directed goals. And so we have access to that 24 hours a day, 7 days a week, and actually review those.

We didn't necessarily want to take ownership over the primary care responsibility. One of the things that you guys were talking about is how do we differentiate between what's the primary care provider's role and what's our role. We view our role more as a consultant type process, where we are really there to kind of help.

And so our initial medication review is really more of a design to say, okay, these are some of the things that we have seen as a geriatric practice group that may put this patient at risk for readmissions, at risk for falls, at risk for other processes. And so we think that this is something that the primary care provider should be paying attention to and the facility should be paying

attention to, and maybe outline that in their goals of care. They can take that information and use it if they want to, they can let us implement some of those things if they want to, or they can not follow any of those recommendations, based on their desire.

We try to have an up-front accounting with the providers and with the facility so that we kind of get an understanding of what their physicians want us to do, what they don't want us to do, and we're pretty flexible in our model, and that's why we built the flexibility in, is to allow some flexibility for other programs to say, you go to your primary care provider group and decide what meets their needs as opposed to what meets my needs, as a geriatrician. So it creates that flexibility.

So the advanced care planning piece we have added to try to allow for us to be able to do that. At 3:00 in the morning I have certainly called family members and said, "This is what I'm seeing. This is what needs to happen if we want to get this patient better. If we don't want to get this patient better, then we can do something different, but I need to know that right now." And so we encourage our providers to make those phone calls. I've called primary care providers before and said, "Just so you know, this is what I'm seeing. This is what I think needs

to happen. What do you want me to do?" And then they give some recommendations at that time and then we have a conversation and go from there.

So it provides a lot of flexibility. We didn't want to force people to say everybody has to have an advanced care planning. We have a social worker on our team who is trained in palliative medicine, and so we do advanced care planning discussions as part of our group. And so we will actually put together a plan for those patients that their primary care provider does not have the time, doesn't feel like they have the skill set to do those types of things. So at certain times we do help in advanced care planning.

MS. KELLEY: One thing I'd like to say, what you're hearing in the delivery of services here across telemedicine is the dance that, philosophically, we believe, we have to augment what's local. We don't want to take over. We want care to remain local. But when there isn't this level of specialists, we want to be in relationship and we want to be in collaboration so that we can bring all of those nursing homes to the same level of quality access to those level of professionals.

So that's part of what you're hearing, is a bit of a dance. Now do we want those, what you're describing

as goals, do we, you know, encourage and ask when can this be finished? All of those things occur, but it needs to be localized too. It can't be a telemedicine goal set. It needs to be the local providership goal set.

DR. FERRIS: Great.

DR. REES: Our social worker reviews every admission, so all those admissions get reviewed and advanced care planning is discussed in every single review, for every -- because every resident gets reviewed under this proposal, and so advanced care planning is discussed. It's up to the facility and the primary care provider to decide if they want to have that conversation, if they want us to have that conversation, or if they're just going to ignore that recommendation, which I find all too often is the case.

DR. FERRIS: Great. I want to compliment you on your answers and highlight that if more groups out there struggled with the balance between accountability and overregulation the way you've struggled with it and come up with a workable solution, then the world would be a better place. So thank you.

CHAIR BAILET: Elizabeth.

VICE CHAIR MITCHELL: Thank you. I want to echo Tim's complements. Believe it or not, my graduate work was

on regulation of nursing homes, and that is the issue. And I also really like this model, and I'm excited by it, which is why my questions are about scalability.

You've said, both in the documents and in your comments, that a key to the success of this is culture change, full transformation across the entire staff, and one of the challenges to this being successful is lack of engagement in the model because of staff turnover or lots of agency staffing, or just -- I'm worried about workforce and capacity, particularly in rural states where most physicians are employed by the hospital, and does that create a challenge for this model?

DR. BASEL: You know, that's one of the key challenges that we think we address, and why we think this is so important that this model is not just a direct care provision model via telemedicine but that care transformation performance improvement, facility-wide, intervention-wide, that's so important.

I mean, we've got facilities -- I can think of one facility we had that went through 11 different directors of nursing and administrators in about a nine-month period, you know, and we are the continuity of care in that setting. And one of the biggest things that we're designed to is to continuously train up that staff so that,

you know, we might teach them about cellulitis in January but that same facility, we may have to go back the next January because they've got a whole new staff.

And we do that one-on-one, each individual call. Again, you're not waking us up in the middle of the night where we're grumpily saying send you to ER. We're like, "Hey, we're up anyway. Oh, you know. So was that leg more purple or is that more red? Oh, I can see it there on the video screen. You know, what I would suggest is -- see how -- I think this is more venous stasis because X, Y, and Z."

So we're doing that training on a one-to-one basis, continually training up that staff. We're also doing it through an asynchronous continuing education piece, and through working with the performance improvement in that facility. And so at the same time that we're providing direct care, we're helping them with that at all stages.

MR. HOFMEYER: And just to add to that, you know, my background is that I was a long-term care administrator. I spent nearly 10 years working in the field, and that was a daily challenge that we had to deal with, was that staffing. And I was actually on the other side of this model when it first came out. I was in a facility that received these services, and we saw it impact the staffing

in a way where we were able to easier recruit nurses and also retain them.

Because if you think about it, the facility I was in, we had 60 residents. On average, about 12 of them were probably receiving post-acute services. The others were long-term care residents but they had a mix of high needs. A handful of them were on hospice. And when we went through night shift at 7 p.m. we had one nurse and two CNAs, for those 60 residents. It's hard to recruit a nurse into that position and then get them to stay.

And this model was able to allow that nurse to feel like they had somebody that they could rely on and call to. And so we did directly see it impact their retention levels as well, and all of a sudden we were able to keep nurses and keep CNAs because they felt like they could actually provide the care that they needed to versus spending their entire shift just running around, putting out fires. They could actually provide care now.

DR. BASEL: That also goes to the physician level as well. One of the first reasons why we came up with this model is that we were seeing, not only in our rural areas but our urban areas as well, is that our primary care physicians were becoming less and less willing to go into the nursing home and be medical directors, or even to admit

patients. And we were saying we've got to get increased support out there. Or, you know, we've got lots of areas where, you know, the biggest length of stay in the hospital is because they can't find somebody to take the patient in the nursing home after that. You know, but by increasing this level of support, all of a sudden we've taken a lot of this burden, especially during clinic hours and after hours, away from them and allowed them to focus on that PCP-clinician interaction. You know, we still get them involved in those care planning discussions because they've got that long-term relationship, and as much as we can support that and keep that intact, we're going to be a lot more successful. And we have seen it.

We worried initially how primary care physicians would view this and that they would see this as a competitor, and what we've found is, I mean, we're selling crack. We give them a little bit of taste and pretty soon you're not taking this away from them.

MS. BELL: The last comment I want to make is that the training itself doesn't have to be that complicated. I think people think telehealth and technologies and rules and regulations and that there has to be, you know, hours or days of training. And what we found is it's really as simple as maybe 20, 30 minutes with

the staff: "Here's what we're here for, call us for help." And then really our team can help walk through any of the other pieces that come up. So from a real technical perspective, it can be fairly simple to keep up with the turnover in the building.

CHAIR BAILET: Len.

DR. NICHOLS: So I want to pick up on this marvelous training up concept of the local staff, and I guess my question is: Given the uncertainties and the complexities that you've discussed and we've outlined, have you considered imposing screening criteria for which nursing homes should be allowed to get it, if you will, on the first round of this? And what sorts of structural conditions or structural characteristics come to mind when I ask the question?

MS. LARSON: This is consistent with all of our telehealth services. We go on-site and do an assessment. We meet both the administrators and the nursing leaders, make sure that there's an engagement level, they want this service.

We also, if possible, would meet the medical director to make sure that they're aware of what is going to occur with this service and are they ready to engage.

What we do know, if one of those three is not

ready to engage, we've got a long row to go, and we may choose not to do that service until, unfortunately, one of those positions moves, either emotionally ready to accept or they move on to a different location.

So we have had the unsuccessful experience of not having engagement of leadership, medical staff, nursing staff, and administrator, and, yes, we know that that does not work. So there is a screening process and a whole assessment that goes in to look at connectivity as well as that leadership piece.

MR. HOFMEYER: And I would just add to that, in the three years that we did the CMMI award and we brought on 65 facilities, out of those 65 that we brought on there was only one that we actually had to leave because we were not able to get them to a level of engagement. And it was a combination of, one, the local physicians along with the director of nursing who had been there for 30-plus years and didn't want the change at that point in her career.

DR. BASEL: But we had a lot more facilities that started out, you know, pretty low engagement at the beginning of this, but, again, as they started to see the benefits of that, you know, sometimes your biggest detractors all of a sudden become your biggest supporters, and it's that process of getting them there.

DR. NICHOLS: No zeal like the recently converted, I agree. But it's perfectly common and normal in PCMH and ACO and everything else to have -- I just wondered if you had specific criteria, so thank you.

CHAIR BAILET: Bob.

DR. BERENSON: I will pursue some of the issues I raised with you. First, in your experience with the HCIA award, what's the mix between SNF patients and nursing home residents, roughly?

MR. HOFMEYER: Roughly, the Medicare population was about 85 -- I'm sorry, 15 percent were on post-acute stays and 85 percent were long-term care. Over 90 percent of them were dual eligible.

DR. BERENSON: Over 90 percent dual. And do you have a death rate, a 12-month death rate, something, ballpark?

DR. BASEL: I don't believe we have that data.

DR. BERENSON: Do 10 percent of the people die? Twenty percent? Eighty percent?

DR. REES: The average length of stay in a nursing home is two years.

DR. BERENSON: Okay.

DR. REES: So most people live in a nursing home for two years, and by that time most of them pass away.

DR. BERENSON: Okay.

DR. REES: So it's probably somewhere around 50 percent, I'm guessing, but I don't have that --

DR. BERENSON: So it's significant.

DR. REES: It's a significant amount, yes.

DR. BERENSON: That's sort of -- my concerns about a shared savings model are just heightened because of that.

So I actually did a study of eICUs and think it's a great technology and have absolutely no problems with the telemonitoring. I think it's a great approach. And what they -- as I understood what was going on with the eICU was that the sort of end-of-life decisions like do not resuscitate, et cetera, was being made by the hospital staff, the attending physician, et cetera, and that the telemonitors were dealing with all of the management -- the management issues without having the responsibility of deciding at 2:00 in the morning whether the patient is a DNR because that's already been worked out. And I could certainly see something like that happening here if the lines -- as you say, there's still a PCP. You're not being asked at 2:00 in the morning to have the discussion ideally as to are we really -- is this patient going to the hospital or is she being allowed to die peacefully in the

nursing home? Those kinds of discussions should have happened -- I mean, Tim has raised these issues. And as you say, your role is a consultant role, and I perfectly get that. So that's how I see this happening.

So, again, I want to ask you -- I mean, the implication of my remarks is: Should you be in a shared savings model for these patients? Or isn't the performance model the right way to go with this?

DR. REES: I'll give you a couple things. So most of our experience is probably dealing with skilled nursing facility patients, which are not the nursing home patients. They're not that population that's passing away, so most of our encounters are with those skilled nursing home patients who have just left the acute hospital and still require some acute care and attention. So I do think that that shared savings model still fits to this picture just because of that large majority of patients that we're dealing with that are skilled nursing facility patients.

DR. BERENSON: I thought we heard that 85 percent were resident.

DR. REES: 85 percent of the people that we served were long-term residents, and 15 percent of the population we served were nursing home patients -- or skilled nursing facility patients. I would guess that it

was 50-50 on number of --

DR. BERENSON: For visits.

DR. REES: -- visits that we had. So 50 percent of the visits were in skilled nursing facility population.

DR. BERENSON: I see.

DR. REES: Fifty percent of those visits were in nursing home patients.

So the other thing that I would say is I had an experience where a PCP had gotten a phone call. The patient was looking like they were having a stroke. The PCP called and said, "Send the patient to the emergency room." The nurse went to tell the patient that they were going to the emergency room, and the patient said, "I don't want to go to the emergency room."

So then the nurse was confused as to what to do. So then she called me over telemedicine, so then I got involved. I called in, reviewed the patient on camera, confirmed that it looked like the patient was having a stroke. Then I called the PCP and said, "Just so you know, this is what's happening. The facility -- you told the facility to send the patient in. I already told the patient that you had recommended transfer to the emergency room." We discussed the case together, came up with a plan, and then I called the facility back and relayed that

plan with them with the PCP.

So we are very involved in the advanced care planning and all of those aspects as we need to be involved. I don't think it was our responsibility to prescribe to other people that try this program to do all those things. That's not me to tell them exactly how to run their program. They have to work out some of those things themselves. And so we wanted to give that flexibility to allow some -- you know, somebody might say, "You know what? We're going to do advanced care planning on everybody." I think what they'll find is that's probably not going to work because people aren't ready for that.

But I think that that scores to that point of saying that we -- that there is a shared advanced care planning, and this is much more of a shared model to allow for some flexibility in those things. And, again, we have that conversation up front to say, "Just so you know, if I get something that I am concerned about, I'm going to call you and ask you about some of these things." And so they know up front that if I as the provider am concerned about something and think they should know something, I'm going to call them back on it.

And so the provider was very appreciative. He

was very happy to have that conversation with me. We, again, worked out everything. The patient ended up going to Comfort Care and passed away shortly thereafter after that stroke. But that was the final wrap-up to that story. But it was an interesting conversation because I was, like, "I don't know what I'm supposed to do in this situation. The primary care provider has already told you to go to the ER, so why do you want me to get involved in this?" And so it was helpful for me to get involved so that I could hear from the patient. I also talked to the daughter who was the power of attorney, and we had a conversation as well. So the three of us had a conversation and had a good chance to make sure that that was what the family wanted, the patient wanted, and then the primary care provider was looped into that conversation after the fact.

DR. BASEL: And you said, you know, the primary care physician should be in charge of advanced care planning, and I agree. In an ideal world, that advanced care planning happened in advance. In reality, that's often not the case. You know, at the end of our first year of our HCIA award, we went back through and looked at all the potentially preventable admissions that we had had that first year, and at that time, you know, there was two probably big themes that it seemed like we weren't hitting

on all cylinders for. One was some of the behavioral health, especially, you know, dementia behaviors and stuff like that. And the other one was advanced care planning. You know, over and over again review a case, boy, we don't -- this doesn't really look like what the patient's goals really would have been if somebody had asked them. And so, you know, we added a palliative certified social worker, you know, to help do some direct advanced care planning, but more importantly, that person worked with all these individual facilities to train them up in their ability to get that advanced care planning process going. They all have a social worker, you know, attached to them in some fashion. They all have primary care and trying to, you know, teach them to fish and get that to happen organically itself, but then when that falls down, you know, we're kind of the backstop on that level as well. And that's kind of a recurrent theme that we did, is looking at those avoidable hospitalizations and look at what were the common theme. I think we'll talk about therapy here in a little bit and is there a need to add therapists to this team model.

You know, one of the things that we found in looking at those, it was almost never did we find a case where, boy, if only that patient had had better access to

physical therapy, they wouldn't have been admitted. But the therapists were great in all the facilities we were. That was one thing that was working really well everywhere we were, and so we didn't necessarily see the need to add that individual as opposed to behavioral concern, yeah, absolutely. Pharmacy? You know, there's a pharmacist in the building one or two days a week as opposed to a therapist in there five -- I mean one to two days a month as opposed to a therapist who's there, you know, five to seven days a week. And so trying to adjust locally -- now, there might be pockets somewhere else where they look at that and go, "Boy, we don't have very many therapists in this community, and that's a member we do need as part of this team." You need the flexibility to be able to adjust to what those local conditions are.

DR. REES: Just one point of clarification. Not all facilities have a social worker.

DR. BERENSON: So I thought that's a -- I mean, your story was a good one in that. I'm happy that that is going on. My concern has to do with a shared savings payment model where in essence you're saying we'll have a strong incentive to reduce spending, but we're going to count on this primary care physician to restrain us. And that strikes me as non-collaborative with a reliance on

tension between the primary care physician and your financial incentives. It doesn't strike me as the right way to go. And so I guess my question is: If it turned out that the PRT -- not the PRT -- the PTAC suggested we have concerns about the shared savings model but we'd like an improved performance model, is that something that you'd be happy with going forward to test the model?

DR. BASEL: So a couple different thoughts there. First, you know, as far as the concerns around stinting and stuff, I do think that PCP element is very effective, and it works. I'll tell you -- you know, Dr. Rees can chime in here -- we will get a call that next morning of, you know, when the primary care physician comes in and sees that we didn't admit that patient with a UA that showed this and that, and, you know, we will get that call, and we have a discussion, and it's like, you know, we feel this is asymptomatic bacteriuria or whatever it is and have that discussion with them. We will get those calls very frequently and have to have that discussion. And once you have that discussion and explain your clinical rationale, it works. But if we don't have the appropriate clinical rationale, that process does work in reality.

A couple other checks and balances that exist in this as well. We felt that we had a pretty robust set of

quality metrics, so, again, if we're stinting care, you know, let's look at the monitoring set. So we've got pressure ulcers in there, the law of unintended consequences. Let's say, for instance, that because we have a nurse as part of the team and the nurse backup, backing up that nursing home, if they feel, oh, we can drop our nurse-to-patient ratio now because we've got some backup through eLong Term Care, maybe they're adjusting patients less frequently and their pressure ulcers go up, you know, that's why we're monitoring some of those sorts of things to make sure stinting of care isn't going on or unintended consequences.

A third infrastructure is some of the other more statutory things that go in around the state survey and those sorts of things. I don't know, Josh, if you want to hit that real quick.

MR. HOFMEYER: Yeah, I can talk about that. There's a lot of things in place already in the long-term care industry, which I'm sure several of you are familiar with, that take place that help monitor those things. There's the ombudsman program, the liaison between the residents and the facility that can help monitor those concerns, as well as the state and federal survey program where they're being surveyed every 9 to 15 months on a

minimum, plus you have your complaint processes and abuse reporting hotlines and different things. And so there's a lot of things that are in play that certainly monitor all of those aspects.

MS. LARSON: Specifically to answer your question, we -- I think everything that you have said as a Committee, did we think we needed a shared savings program to be in here to satisfy some of what was being requested by CMS, I think the answer is yes. But did look at one that we thought could work? The answer is yes, but we knew there were shortfallings and it was going to be difficult.

Are we -- in our backgrounds as a health care system, we're used to being able to start and get engaged with performance measures and to really move through that process to get adoption of performance measures and then maybe move into shared savings such as what we're doing in the rest of the health care continuum. Do we think that that's a modality that we could take? Yes.

DR. BERENSON: So let me just pursue that. Is it your -- was it your perception that CMMI wanted you to have a shared savings model to be viable?

DR. BASEL: Not necessarily CMMI, but, I mean, if you look at the national -- everything that's coming out nationally right now, there is definitely, we're feeling, a

big push to move, you know, from Type 1 fee-for-service to Type 2 to Type 3 --

DR. BERENSON: I see. So MACRA was a contributor to that. Okay.

DR. BASEL: Yeah, absolutely. And even if you read through -- I read through the PTAC RFP again last night, and there's very strong language about it, you know, ignore more advanced models at your own peril. Now, we understand that, you know -- and certainly as we listened to the PTAC deliberate over the last couple of meetings, you guys are not as strongly that way. But I still don't think that it's clear that CMS themselves are not there --

DR. BERENSON: That's why I asked the question, is we need that kind of feedback for ourselves, and they need to --

MS. LARSON: So we took a little bit to get to the answer, but --

DR. BERENSON: Yeah, so let me ask -- I've been taking up a lot of time, too. My final question relates to what I raised about the lack of alignment between Medicare and Medicaid. You've said that's real, but we can -- we can still do this model, and it's not a disabling problem, as I understood your answer. Could you say more about this?

DR. BASEL: At least in our state, that has not been too much of an issue. We met -- one of the first things we did when we were kicking off this model is we met with our own state Medicaids, and we got a letter of support from the State Department of Health for South Dakota. You know, they've been aware of what we're doing and haven't been that concerned all along there. So it hasn't been that big of a deal in our experience, that interaction.

Now, I totally see, you know, there's that perverse incentive for Medicaid to send them back to the hospital, but it hasn't -- operationally, it hasn't seemed to be that big of a deal. Josh?

MR. HOFMEYER: You have to get the facility to understand what the advantages of our program are over what the current status quo is. So if you go into a rural location and they're dealing with a critical access hospital who doesn't get penalized for readmissions, and they can send them there and get a three-night qualifying stay and bring them back on Medicare, more money to them, that's fantastic.

But what we do is we go in there and we help them understand what are all the downsides to doing that. You've now taken staff time to transfer the person out.

You have to bring them back in. Now we have to start the MDS process all over again. We have staff time getting them acclimated. Over 30 percent of the residents who go to the hospital come back sicker than they were before they ever left. So now your staff is stressed because the resident that they knew is not the resident who returned. So it's a recruitment and retention component. It's a staff overtime wages component. There is the value-based purchasing that's now coming into play with long-term facilities that does incentivize them to have lower readmission rates and ED transfers, among a lot of other different things. But it is a conversation that you do have to have to get that culture change and that mind-set to start to sway to what the future of medicine really needs to be versus that we're going to send everybody to the hospital and maybe they'll come back on Medicare.

DR. BERENSON: So my last question, just to follow up on that, would be -- I like your model. It has potentially much broader applicability. But Evercare has been around for 20 years in the current environment. Why hasn't there been broader adoption of a model that seems to work and would deal with those perverse incentives that already exist? Isn't this a bigger -- I guess the hypothetical is: Isn't this a bigger barrier than you're

suggesting? I guess is the question.

MS. BELL: I think the advantage of this model over Evercare is it does preserve more patient choice so that they're not giving up their provider for the Evercare provider, and it's available for more facilities. I don't know exactly how Evercare decides which facilities they go into, but they've got to have a concentration of patients that's high enough to make it worth their while. So having this model in place allows the entire population of the facility to be cared for without making that tradeoff between giving up my trusted PCP for another provider, as well as it's much more cost-effective --

DR. BERENSON: But I'm getting at the nursing homes want to do this? I mean, they do want to have a model that would prevent people from going to the hospital to qualify for the three-day stay? You're saying that all of these other factors are significant enough. Do they understand that, or do you have to do a marketing job to convince them that it's in their interest to have this kind of a program?

MR. HOFMEYER: In our experience, most of them understand that. They're starting to see where medicine is going and that they need to fall in line with that, especially with all the value-based purchasing initiatives

that are coming out.

If you go back five years ago, you know, you had to do a lot of marketing around this to get people to understand that you would want this model. But over the last five years, I've seen a lot of change in that mind-set, and it is a lot simpler to get people to understand and adopt our model today than it was five years ago.

DR. BASEL: They're just now starting to feel the downside of value-based purchasing, and they're really waking up to that, you know, a lot more than they did a few years ago.

MS. LARSON: And they also are now seeing the value of their star rating. So if we can improve that, they can actually be a destination center for those patients. They're starting to see this as their own marketing ploy that they have access to this level of care 24 hours a day. So it changes their mind-set. But it's -- it is work to do this. It is work to go and introduce what this concept model is. It is work to get to each levels of leadership we described, and that's not something we just send out a flyer and that they're going to buy onto. You're exactly right.

MR. HOFMEYER: And I don't want to belabor the point, but if you do send somebody to the hospital, there's

no guarantee they're coming back to you on Medicare. They could be going back to your competitor on Medicare because they're angry that you sent them to the hospital to begin with.

DR. REES: The two points that I have is sometimes people have been using it as a recruiting and retention program as well, so that increases their recruitment and retention, both of nurses and of physicians. We've had several facilities where a nurse who was in the program went to a different facility and said, "You guys should try eCARE," and then we get started in that facility because the nurse was like, "This is a great program. This will help keep nurses here and providers satisfied."

The other thing is anytime you send somebody to a hospital, they always come back sicker than when they left. So it also creates, you know, a more difficult patient to take care of and to treat if you send them to the hospital, and so we're getting a little bit of buy-in from that direction as well. So anytime you send somebody to the hospital, they -- very rarely do they ever come back better -- unless they're going in for elective surgery.

CHAIR BAILET: Grace and then Paul.

DR. TERRELL: I want to get into mostly just to

get your thoughts on this. It's not specific, per se, to your proposal, but a lot of what you're talking about is important in there.

There is a lot of emphasis right now at CMS, and we've had a lot of discussions about it. Mr. Miller, in particular, has been our champion for this of being able to provide models of care for those with small or rural practices.

So one of the points that you've made is that by having this service, it supports primary care possibly in small and rural areas. It's a very different thing from saying that a small or rural practice or somebody that doesn't look like Avera Health could provide the services that you do.

So I want to get into a little bit about the 5,000 beneficiaries as being a unit that you need to provide these services and really get to an understanding of how much about the two different models is about trying to meet some of these concerns or breadth of possibilities for other providers versus what you really think is sort of the best model based on your experience.

I could see making the argument that it requires scale to do this well, but -- and that you're not going to get somebody who's of smaller scale be able to do this,

much to Mr. Miller and many of us consternation, that the simpler model therefore might not work. But it's a way of actually supporting other types of providers in those environments such that they can remain open and viable.

So that is an argument that you all didn't make, but what I want to think about before we start thinking about the payment and the split that you all made is how important the scale is to the actual performance in your thought process, if that makes any sense to you.

DR. BASEL: So, obviously, we believe in our model, and we believe in the specific members of our team that we added and stuff. But just because we had success doing it one way -- you know, I grew up on a small family farm. I'm never going to underestimate, you know, the power of a very committed, passionate -- lots of innovation and ingenuity and a ton of hard work, that you value your own hard work very cheaply of being able to do this on a much smaller scale. And I don't want to discount that possibility.

Now, where -- if you take this too far that direction, the one caveat that I want to make absolutely sure, if you go too far down that route, if you say make this to a -- we've got a two-person geriatric practice that's going to implement this, at the same time they're

going their clinic work and at the same time they're seeing some patients in the hospital and being medical director of several nursing homes, all of a sudden, you've deluded this down to where it looks a lot more like the status quo where they're not wanting to get up in the middle of the night and answer phone calls or they're not having -- "Oh, I don't want to mess with advanced care plan. I'm not going to have the conversation with the family. I got to get up and have clinic the next morning." If you take it too far that direction, you're going to lose too much aspects of this.

And where that sweet spot, where you cross over to there, you're right. That's a huge unknown at this point.

I don't want to preclude that. That's why you put in that accountability piece. Great. Put the payment model out there if you think you can do this because if you go too far towards the status quo, guess what? You're not going to be successful, and you're going to be out of this business pretty darn quick type of thing. So I don't want to preclude that.

MS. LARSON: You know, one thing I would say is just the evolution of medicine, right? Twenty years ago, we really didn't have critical care intensivists. We had

surgeons and cardiologists that were trying to get up in the middle of the night and answer questions. The nurses waited until morning when they thought they could actually talk to the internists, all medicines. All of a sudden, we have hospitalists, and none of those guys answer any of their phones during the middle of the night.

So this is a specialty practice, and how do we start to make access to geriatricians available?

MS. BELL: I think the other thing that we have seen in recent years is just the creativity and flexibility of how the model has allowed teams to come together, and so there's nothing to say that a small practice couldn't even use telehealth to recruit other members of the team to fully implement this model in a very cost-effective way.

So if they have one nursing home they really want to concentrate on, they want to be the primary member of that team using telemedicine to recruit others into their team to flesh that out would be very possible.

DR. BASEL: The other point that I want to make before we get back away from it too much is the question of should we mold these two payment models into a single omnibus payment model type of thing.

I think if we had done that initially, we would have faced the same criticism that the palliative care

project did with two tiers yesterday where we said this is too complex. It shouldn't be that complex-type stuff. And I still feel that's a valid argument type of thing.

And so I do think that more CMS and PTAC is going to need to make that decision. Do we care more about accountability? From a patient perspective, there's enough geriatricians to do this model and cover all the nursing home beds in the U.S., even if only 10, 20 percent of geriatricians were to adopt this model. We ran the numbers. We can cover it from a patient perspective.

Now, from a physician perspective, we want to have broad-based APMs available to as many people, and if that's more important, that flexibility to get as many physicians into the APM door as possible so that we can all learn to go through a value-based care and stuff -- and if that's what CMS care is about, then you start the other direction.

You know, Avera is an entity -- we are, you know -- we really just put the shared savings model in place for the PTAC. Going back to initial HCIA application, we were asked to come up with a payment model, and that was our initial payment model we proposed, going clear back to the HCIA days, because we do feel that that could work in that model.

However, trying to open the door to get this adopted by as broad as people, it's really going to restrict the number of people that would be willing to take on any amount of risk without a lot of history in the space type of thing. So if you ask what is our true feelings on this, you go with the performance-based payment piece right now with the intent that through administrative rules or another process, you add on the secretary model.

It's just like through the shared savings. You crawl, walk, run, and so you start with performance-based payment. On down the road, you get people in it, comfortable with it, and then you can add the shared savings component on down the road. You've got more data to look at it at that point, and so I truly think that's probably what should happen, but I'm not sure if that's what CMS thinks should happen.

DR. REES: Just from my experience, do I think I could do this with less of a team than I have now, which would be more realistic to a small practice? Probably, if I had a very good interdisciplinary team at a nursing home that I was medical director over or was at. Do I think I could go to, let's say, a small rural nursing home and say I want you guys to help me do this project and I'm going to be on call? Would I want to be on call 24 hours a day, 7

days a week? Probably not, especially to do telehealth because of the calls. I mean, as you start gaining volume, then you start gaining more and more calls, and you're awake much more in the evening.

So I think it would be doable. I think it would take the right environment to do that. I don't think that every rural geriatrician is going to be like, "Okay. Let's start this program up."

But I do think there is some opportunity for them to say, "You know what? If I have a really good interdisciplinary team and feel very comfortable with them, they might just try it in their own nursing home, and it might work for them in their local community as opposed to expanding and covering 5,000 providers or families or nursing home beds."

So I think it would be a little bit difficult for them to cover multiple nursing homes and multiple facilities. I think it would be doable -- you know, right now I have a license in all the states that we practice in. I have a DEA number, and I have credentialing at all the nursing homes. And so that part of the process in and of itself is a little bit difficult to have a small rural doctor do that.

But I think if they did it locally, I think it

certainly could be done.

CHAIR BAILET: Thank you. So, again, thank you guys for coming. Thank you for your proposal, and we're going to move into our next phase, as you guys change out and take your seats.

We have one person here in person. Kara Gainer from the American Physical Therapy association.

Thank you.

* **Comments from the Public**

MS. GAINER: Good morning. My name is Kara Gainer, and I'm here on behalf of the American Physical Therapy Association, which represents more than 100,000 physical therapists, physical therapist assistants, and students of physical therapy. Thank you for the opportunity to provide public comment here today.

I did write up a full statement about physical therapy and how they play a role in the skilled nursing facility and why they should be considered for the care team, but I did obviously hear the comment made by Avera about the consideration for inclusion of physical therapists or other therapy providers on the care team. And that makes sense, what they said.

So now I just have more of a suggestion as we look ahead to the changes coming down the pike to post you

-- eCARE payment. Based on what Avera said, obviously physical therapists are present at the skilled nursing facility frequently, but the changes that CMS is considering to the SNF payment system is going to decrease the demand for therapy, and so the demand for therapists will decline by no longer tying therapy to payment. Obviously, that's going to have an impact, so I would just suggest that PTAC and Avera look ahead to what's coming down the pike and consider how the changes to payment will impact access to therapy and why in fact it may make sense in the future to include therapists on the care team.

Thank you.

CHAIR BAILET: Thank you.

We have one person on the phone, potentially, so I'm going to ask the operator if there's someone on the line.

[No response.]

* **Committee Deliberation**

* **Voting**

CHAIR BAILET: All right.

So we're going to -- here comes my Vice Chair. So we're ready to vote on the criteria. We're going to go ahead and start that process.

Here he comes. I feel a pulse in the force.

Okay. We're getting the band back together again here.

So we're going to go through the 10 criteria. Ann, are you ready to go?

MS. PAGE: Yes.

CHAIR BAILET: All right. So scope, high-priority item, aimed either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM entities whose opportunities to participate in APMs have been limited.

It's a high-priority item. Please vote.

[Electronic voting.]

* **Criterion 1**

MS. PAGE: One member voted 6, meets and deserves priority consideration; six members voted 5, meets and deserves priority consideration; two members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet.

The majority finds that the proposal meets Criterion 1.

CHAIR BAILET: Criterion 2 is quality and cost --

MS. PAGE: Meets and deserves.

CHAIR BAILET: What?

MS. PAGE: Meets and deserves priority consideration on Criterion 1.

CHAIR BAILET: All right.

MS. PAGE: Just clarifying, meets and deserves priority consideration.

CHAIR BAILET: Very good.

Cost and quality, anticipated to improve health care quality at no additional cost, maintain health care quality, while decreasing cost or both improve health care quality and decrease cost, a high-priority item.

Please vote.

[Electronic voting.]

* **Criterion 2**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; seven members vote 4, meets; two members voted 3, meets; and zero members voted 1 or 2, does not meet.

The majority finds that the proposal meets Criterion 2.

CHAIR BAILET: Thank you, Ann.

Criterion 3 is the payment methodology to pay the APM entities with a payment methodology designed to achieve the goals of the PFPM criteria, addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM entities, how the payment methodologies

differ from current payment methodologies, and why the physician-focused payment model cannot be tested under current payment methodologies.

A high-priority item. Please vote.

[Electronic voting.]

* **Criterion 3**

MS. PAGE: Zero members voted 5 or 6, meets and deserves priority consideration; two members voted 4, meets; seven members voted 3, meets; one member voted 2, does not meet; zero members voted 1, does not meet.

The majority finds proposal meets Criterion 3.

CHAIR BAILET: Criterion 4 is value over volume, provide incentives to practitioners to deliver high-quality health care.

Please vote.

[Electronic voting.]

* **Criterion 4**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; seven members voted 4, meets; two members voted 3, meets; and zero members voted 1 or 2, does not meet.

The majority finds the proposal meets Criterion 4.

CHAIR BAILET: Criterion 5, flexibility, provide the flexibility needed for practitioners to deliver high-quality health care.

Please vote.

[Electronic voting.]

* **Criterion 5**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; four members voted 5, meets and deserves priority consideration; five members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet.

The majority finds the proposal meets Criterion 5.

CHAIR BAILET: Criterion 6, ability to be evaluated, have evaluable goals or quality of care cost and other goals of the PFPM.

Please vote.

[Electronic voting.]

* **Criterion 6**

MS. PAGE: Zero members voted 5 or 6, meets and deserves priority consideration; five members voted 4, meets; five members voted 3, meets; and zero members voted 1 or 2, does not meet.

The majority finds the proposal meets Criterion

6.

CHAIR BAILET: Criterion 7, integration and care coordination, encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to population treated under the PFPM.

Please vote.

[Electronic voting.]

* **Criterion 7**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; three members voted 5, meets and deserves priority consideration; four members voted -- six members voted 4, meets; zero members voted 3, meets; one member voted 2, does not meet; and zero members 1, does not meet.

The majority finds the proposal meets Criterion 7.

CHAIR BAILET: Criterion 8, patient choice, encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

Please vote.

[Electronic voting.]

* **Criterion 8**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; three members voted 5, meets and deserves priority consideration; six members voted 4, meets; one member voted 3, meets; and zero members voted 1 or 2, does not meet.

The majority finds the proposal meets Criterion 8.

CHAIR BAILET: Criterion 9, patient safety aimed to maintain or improve standards of patient safety.

Please vote.

[Electronic voting.]

* **Criterion 9**

MS. PAGE: Zero members voted 6, meets and deserves priority consideration; one member voted 5, meets and deserves priority consideration; seven members voted 4, meets; two members voted 3, meets; and zero members voted 1 or 2, does not meet.

The majority finds the proposal meets Criterion 9.

CHAIR BAILET: And finally, Criterion 10, health information technology, encourage the use of health information technology to inform care.

Please vote.

[Electronic voting.]

* **Criterion 10**

MS. PAGE: One member voted 6, meets and deserves priority consideration; four members voted 5, meets and deserves priority consideration; two members voted 4, meets; three members voted 3, meets; and zero members voted 1 or 2, does not meet. The majority finds the proposal meets Criterion 10.

CHAIR BAILET: Thank you, Ann.

Do you want to summarize?

MS. PAGE: The proposal found on -- for the first criterion, scope, the Committee determined that the proposal meets the criterion and deserves priority consideration, and on the remaining nine criteria, the proposal was found to have met the criteria.

CHAIR BAILET: So I open it to my colleagues. Any comments before we vote to make the recommendation to the Secretary?

[No response.]

CHAIR BAILET: So that's the last phase. We're going to use an electronic methodology first and then go around the room and share how we voted, starting with 1, did not recommend the model; 2, recommend the proposed payment model for limited scale testing; 3 is recommend the model to the Secretary for implementation; and 4 is

recommend the model for implementation as a high priority.

So we are going to go ahead -- yes, Tim.

DR. FERRIS: Just to clarify, you in describing what we're doing said the model, and we had a discussion about the fact that there are actually two different models here. I just wondered how my colleagues or you, Mr. Chairman, would like us to consider the fact that there are two different payment models here in making this vote.

CHAIR BAILET: Len.

DR. NICHOLS: Thank you for the question, Dr. Ferris.

Here's how I'm dealing with it. We're basically saying is this worth moving over to the CMS side of the pile, and then we'll have a discussion, in my view, about how to word the letter to the Secretary to point to these many conditions that we would like to put on.

So I think it's not Model A, Model B. It's rather is this worth moving over to the CMS side of the pile. If so, then we'll have lots of words about how to do that.

DR. FERRIS: Thank you.

CHAIR BAILET: Bob?

DR. BERENSON: Yeah, what I'm thinking about is there at least one payment model here that potentially

could work, rather than us endorsing all the proposal, I guess is how I'm thinking about it.

CHAIR BAILET: Any other comments before we vote?

[No response.]

CHAIR BAILET: All right. So let's go ahead and vote on the recommendation.

MS. PAGE: And a reminder that the recommendation to the Secretary is determined by a two-thirds majority of votes, and that will be 8 votes from the Committee.

DR. NICHOLS: Seven.

DR. PATEL: Seven today.

MS. PAGE: Who's missing?

MS. STAHLMAN: Rhonda.

MS. PAGE: Oh, that's right. Sorry. 10. 7 votes. Thank you.

[Electronic voting.]

* **Final Vote**

MS. PAGE: Two members voted 4, recommend the proposed payment model to the Secretary for implementation as a high priority; four members voted 3, recommend the model to the Secretary for implementation; four members voted 2, recommend the model to the Secretary for limited-scale testing; and zero members voted do not recommend the payment model to the Secretary. The two-thirds majority

would determine that this is a recommended to the Secretary for limited-scale testing.

CHAIR BAILET: So review the math again for me.

MS. PAGE: So we start at the top and we roll down until we've acquired a two-thirds majority, which would be seven votes. So 2 plus 4 is 6, which isn't equal to 7, so you roll down one more until you catch that seventh vote.

CHAIR BAILET: I understand. Okay. Sorry. Common Core. I don't know.

[Laughter.]

CHAIR BAILET: So it's limited-scale testing.

MS. PAGE: Correct.

CHAIR BAILET: Bob?

DR. BERENSON: I think we have to revisit that rule of scaling down. It suggests that this is all on a continuum, and that limited-scale testing is just a miniature version of 3 and 4, when, in fact, it's an alternative, which some people think is appropriate only for some kinds of proposals. So, you know, we have 6 who support either high priority or implement, and yet we're going to roll down to doing limited-scale testing.

CHAIR BAILET: Right. So 6 was implementation, right?

DR. BERENSON: Yeah.

CHAIR BAILET: I mean, it's in the implementation bucket. It's just whether it's high priority or not.

DR. BERENSON: We haven't gotten 7, but it's closer to 7 than 4 is, is my view, and we shouldn't be rolling down. We should maybe vote again or do something. I don't know exactly how we resolve this.

CHAIR BAILET: Okay. So Kavita is suggesting potentially revoting, which we will do. Len, you have a comment?

DR. NICHOLS: Well, this came up yesterday, because in my simple opinion 4 is bigger than 3, and 3 is bigger than 2. It ought to be a weighted average of the numbers, because that's intensity of preference. Now I agree someday back in the past we agreed to do this roll-up bullshit, but I'm telling you right now a better mapping of our intensity of preferences would get you on the other side of the line, and all we've got to do is change the weighted average of the roll-up. It's not complicated. It's not even math. It's algebra.

DR. TERRELL: That will lead to grade inflation, though. You can politic that.

DR. NICHOLS: Say again?

DR. TERRELL: If I know that if I vote higher,

it's more likely to, you know, move the number with respect to the average --

MS. PAGE: That's what I did.

DR. TERRELL: -- we will inflate grades.

MS. PAGE: I mean, I did it yesterday.

DR. NICHOLS: So grades are already inflated. My point is --

CHAIR BAILET: All right.

DR. NICHOLS: -- no, no, no. We agreed to have these different numbers precisely because we thought they meant something, just like there's barely meets and really meets, and there's high priority and there's really high priority. And what we did was try to rank these in order, and all I'm trying to say is the intensity of -- if you map this in a normal bunch of mathematicians, they would give you over the line. Just saying.

CHAIR BAILET: Okay. I've got three of my colleagues -- so, Tim, you're just --

DR. FERRIS: I would make a motion that we each go around and explain our vote, and then we revote, because I'd like to hear what everyone was thinking about why they voted the way they did.

CHAIR BAILET: So Harold and Bruce, do you guys want to make additional comments or do you want to follow

up? Let's go?

MR. STEINWALD: I want to -- as usual, I want to do what Tim said.

[Laughter.]

CHAIR BAILET: It's your time to shine, Tim. I'm going to let you go first.

DR. FERRIS: Well, Bob already went, right?

DR. BERENSON: No.

DR. FERRIS: Okay. All right. So I didn't have a clear -- my voting was not clear here. Here is wanted -- start with the outcome, which is, actually, I think the payment model that I preferred of these, that, you know, the least, as according to Bob's voting, is there one that you like here. Actually, I think, to me, the first model, the one without the shared savings, is my preferred one, but I also didn't think there was sufficient accountability in that model. So in some sense, actually, I should have voted, you know, do not recommend, because I didn't actually see a model here.

On the other hand, I don't think the barriers to getting to where I want to go, and from the responses that I heard, like this isn't rocket science to get that increased accountability in there. Actually, I'm not so sure -- I use a rate per thousand to evaluate all nursing

homes in my region, and, like, that's not hard to do. It's really easy data to collect and it's a fine performance measure.

So I think we're actually very close to something that's implementable on a wide scale. And because of the importance of this issue and the need for a new payment model to solve a critical public health problem for U.S. citizens, that's why I went to implementation, because I actually don't think we need small-scale testing. We could do this at a large scale, in one year, get the data necessary to do the pay-for-performance in Model 1, and we'd be -- we'd have changed the landscape of health care for Medicare citizens in the United States, which I think would be a very positive thing to do.

CHAIR BAILET: Grace.

DR. TERRELL: I voted 4 for highest priority, and my rationale for doing that is related to what I heard in their testimony today, which is that they have thought through this so -- with such depth, that if we implemented it relatively fast, with the work that they would be able to do with CMS, that it could actually impact the lives appropriately for a large number of people for whom this would be a great service.

So I am not going to disagree with anybody who

talks about their concerns about various aspects of the payment methodology, but just like at the PRT, where we said we think that there's weaknesses here and there but that overall it meets all the criteria, I think that's still the case. But I have a lot of confidence that if they are working with CMS as part of that process that making the move to -- move forward in a rapid, high-priority way would be -- would really be a solution, quite frankly, to what ought to be considered an emergency in the U.S., which is the way we actually take care of patients in most nursing facilities.

So that's my logic. I'm sticking to it.

CHAIR BAILET: Harold.

MR. MILLER: So first of all, as the mathematician in the crowd here, on the voting scale I would observe that I think the problem is we have a one-dimensional scale for a three-dimensional decision. What I heard we've done frequently is there's a question of -- whether there's a question of how and there's a question of how quickly something should be done, and we are all sort of struggling with that.

So should it be done at all? Does it need to be done on some limited scale or on some broad scale? And should it be done quickly? And, you know, we were somehow

-- people were picking priority because they wanted to emphasize the priority part, you know, even though they'd rather have limited-scale testing.

So I think it's problematic to have a one-dimensional scale and then try to figure out, kind of, how to weight stuff when people have three different dimensions. But we can explore that at a different time.

I voted for number 2, and it was because I see two different things going on here. It seems to me that Avera is doing this, it seems to be working, it's another example of the HCIA award that is expiring and that there is no way to continue it, and it seems to me that it's a travesty to not have a way to continue that. But it also seems to me that what Avera is doing is potentially, almost by definition, a limited-scale model, because it's not clear to me how many Averas there are and how many of them will materialize right away to be able to do this.

Where I think the opportunity is, is to find a way to do this more broadly and not to require it or force it to be just places that can do 5,000 beds or more. And I believe at the moment we don't know exactly how, really, to specify the model. We don't know exactly how much that's going to cost, and we don't know exactly how to define benchmarks for that, and that's why it would seem to me,

again, I think quickly, and I think with a focus on trying to get this done in some small and rural areas, and to get some actual independent geriatrician practices to see if they can do it, et cetera, et cetera, would be to try to figure that out.

So that's kind of why I put limited scale in there, is because I think the small scale needs a little bit more exploration first, which I think is only going to be figured out. This is my model of what limited-scale testing is for, is it's only going to be figured out by actually trying to do it in a few places first to see what it costs and what's going to be involved with that, et cetera.

CHAIR BAILET: Paul.

DR. CASALE: So I was really on the fence on this and I voted for 2, although if my finger were a little fatter it might have gone to 3. I really struggled because I was really in between on this, to be honest with you. And I think Harold has articulated the two areas that I also thought about, which were around the benchmarking and then the scale, and how do you figure out who can actually do this. So that's where I ended up on 2 instead of 3, although I have to say I struggled quite a bit.

CHAIR BAILET: Bruce.

MR. STEINWALD: I voted 3, implementation. In contrast to yesterday, where even though I thought that the model should be a high priority, I thought that -- this is, I guess, the hospital-at-home model -- I thought that there was one important technical issue that had to be resolved before it was implemented. It had to do with the favorable selection issue and how that should affect the rate at which the model would be paid.

I don't see that issue here. I don't see that there's something like that that's needed, before getting a model into the field. Which model is still for discussion? And for that reason I didn't see anything that would stand in the way of implementation.

CHAIR BAILET: And I voted for implementation, 3, and again, we can have -- I think we do probably need to have a discussion about -- revisit high priority. Because as I framed it up in my mind I know that there's a limited, albeit I'd like to see it as wide as possible, I still think there's a finite amount of models that CMS can implement in any given year, and for me, when I think about high priority I was looking at it where these models fall out in the queue. So there's so many models that we are recommending but a high-priority item means it sort of jumps ahead of the line. At least that's how I see it,

rather than -- now, again, you could translate that into speed but I'm not necessarily sure that it's rapidity. I think it's just where it is in the queue. That's my own interpretation of that but I think we do need to revisit it.

I think that this model, out in the field, will -- I think it will accelerate innovation, because there's a path to providing this kind of care to the skilled nursing home facilities. So I think implementing it. I'm not sure there's -- I didn't see a lot of mechanical challenges relative to the model itself that would require wet-labbing it in a small-scale environment. I think there's enough out there that they could implement it. So again, I voted 3.

CHAIR BAILET: Elizabeth.

VICE CHAIR MITCHELL: I actually voted 4. It's the first time I've ever used the 4. And I found myself in the Bruce Steinwald category of high priority, limited testing, but does it exist. So I went with high priority as an urgency, for a lot of the reasons that Grace mentioned -- the need, the lack of options, the patient population. I just thought we've got to do something.

And then I had some of the same concerns as Tim around accountability and measurement, but I was so

impressed with the depth of experience and insight that I thought it was all very solvable, so I went with 4.

CHAIR BAILET: Len.

DR. NICHOLS: So I went with 2 because I thought there were enough details that needed to be worked out, I mean, benchmarking, risk adjusting. I just think if you get beyond people who really know what they're doing and you don't have it risk adjusted, it's not going to be pretty. So I just think we need to do that before we go forward, and that's what I mean by limited scale. Let's work out the parameters. I would like to say limited scale fast, but I can't, but that's where I am.

CHAIR BAILET: Kavita.

DR. PATEL: I also voted number 2 for exactly the same reasons, and wanted to limited scale with a high priority, but if we revote I'll let my revote reflect the impression I want to send to the Secretary.

CHAIR BAILET: Robert.

DR. BERENSON: Yeah. So I voted number 3, and I support it for the reasons Tim laid out. I like the one payment model but not the other payment model, and if we agree we can reflect that. So I was satisfied that this is a potentially viable model.

I didn't go for 4 because I still think there's

probably barriers to broad adoption related to Medicare-Medicaid interactions, so that, similar to Jeff, I didn't think this was ready to go as the highest priority. Some of that has to be worked out. And I didn't go for 2 because I think there's been eight years of experience at CMS and the Duals Office. They probably have some of the answers that we need in terms of the data.

So we've got this fuzzy line between 2 and 3, and in this one I actually think CMS needs to be pursuing. I mean, almost all of their demos in the duals were capitated demos. They had real problems getting buy-in because beneficiaries correctly could opt out. Many of them did. We need some fee-for-service models. This is a fee-for-service model. And so I think it is more than 2, so that's why I came up with 3.

Oh, and I wanted to say one final thing while I have the floor here. I think it's regrettable, and we should do a better job, that the whole world thinks that a proposal has to meet the criteria for an advanced APM rather than an APM, and that's what one of you articulated, is you think that MACRA or CMMI or somebody is requiring you to offer up taking substantial financial risk when that's a subset of APMs. And this strikes me as perfectly good for an APM but maybe not appropriate for an advanced

APM. My own personal view is that both MACRA and CMMI are wrong in having that be the only criteria that gets you to an advanced APM, but that's the world we live in.

So I support an APM for this but not an advanced APM.

CHAIR BAILET: Thank you, Bob.

CHAIR BAILET: So we're going to go ahead and revote. Let's just do it.

[Electronic voting.]

* **Final Vote**

MS. PAGE: Three members voted 4, to recommend to the Secretary for implementation as a high priority; six members 3, to recommend to the Secretary for implementation; and 1 member voted 2, recommend it for limited-scale testing. So the two-thirds majority finds that this proposal should be recommended to the Secretary for implementation.

CHAIR BAILET: Thank you, Ann.

* **Instructions on Report to Secretary**

CHAIR BAILET: So we already have made a lot of comments so it's perfectly fine as we go around if you don't want to add anything to your comments already. But let's just go ahead and start again with you, Tim, and we'll just rip around the room here.

DR. FERRIS: Nothing to add.

DR. TERRELL: One thing to add.

DR. PATEL: Say how you voted.

DR. FERRIS: Oh, I'm sorry. Yes. That's right. So I kept my vote the same and I voted 3, and I have nothing to add. I'm glad to see that the Committee came around to my way of thinking.

CHAIR BAILET: We always do.

DR. TERRELL: I voted 4. I do want to add one thing, and that is it's probably a difference between something that Harold and I believe, but because it continues to come up in various things I want to just sort of note it.

And I don't think there's anything in the Secretary's criteria that says we have to make sure things work in all different types of practice settings. It doesn't say that it has to work in rural or, you know, small practice settings. And so as we're thinking about the scalability issue and limited testing, one of -- my interpretation, Harold, of one of your points is we need to see what types of settings it works in, and at least that's what I've heard you say.

If that's the case, we need a different and broader conversation, I believe, is PTAC about that,

because we don't want to necessarily use that as a rate-limiting factor with respect to good ideas that ought to be implemented. There may be some really good things for rural America -- I think this is one of them -- that may -- it may be that it can only be done in the way that Avera does it. That's okay with me, and if it's not okay as a criterion then I don't think -- we need to be explicit about that, because I think that's something that we've kind of danced around.

So I just wanted to sort of, you know, bring it out. I'm not saying that my opinion is the only one that matters in this but I do think that as a PTAC we ought to be more articulate about differences we might have about that.

CHAIR BAILET: Thank you, Grace. Harold.

MR. MILLER: I was persuaded by my colleagues, and I changed my vote to 3 for implementation. I would like to suggest, because I do think that it makes sense to move forward with what is movable forward on. I would suggest -- again, if others would agree -- that part of our recommendation, though, be that the implementation of it give special attention to facilitating the participation of smaller practices.

Medicare has, for example, in its ACO programs,

created special add-ons for advanced payment for small physician practices and for small hospitals, et cetera, to try to deal with the fact of differences in resources, et cetera. So I think it would be desirable to not simply put it out as a model that only large practices could do but at least try to do that.

I would also just separately say I think this is yet one more reason why we need to send the letter about the HCIA awards, because the notion that a good project cannot get an evaluation, nor can we, for a year after it is over is just -- does not make good sense. And the fact that people are coming to us for payment models to continue something that appears to work, rather than having had that already resolved by CMMI, I think is a problem, and I think we need to speak to that.

So that's not necessarily -- I mean, I think we can mention that in this report but I think we've agreed separately we need to comment on that, kind of as a freestanding letter. This seems to me to reinforce the need for that.

CHAIR BAILET: Thank you, Harold. Paul.

DR. CASALE: Yeah. So as I said I was on the fence so I did switch to 3, implementation. The only comment I'd add is in terms of comments, and this was also

reflected yesterday in palliative care. Others have made the comment that for those in ACOs, you know, the palliative care work is part of what you're doing, and this type of work is also what you're trying to do, in terms of lowering costs and improving quality. And so the comment about how all the models will interact within the ACO world I think could be emphasized again in this model, and should be.

CHAIR BAILET: It's a good point. Thank you, Paul. Bruce.

MR. STEINWALD: I kept my vote at 3, implementation, but I think Paul has made a good point.

CHAIR BAILET: I also remained at 3.

VICE CHAIR MITCHELL: I was not persuaded by Tim and kept my vote at 4. I was persuaded by Bob, though, and would double down on the urgency, given the history and experience to date that could be built on.

DR. NICHOLS: So I was persuaded by all my colleagues but not enough to change my vote, because we didn't solve the risk adjustment benchmark problem. And what we haven't talked about enough, in my opinion, although I won't make it long, is this notion of the two models offered up by the people who have thought about it the most. I definitely agree I don't like everything about

either model, but I think both of them are fixable. However, what I think we ought to say to the Secretary is, you know, don't pick one. Fix both or do this hybrid, which the PRT called for.

I must say, as great a job as you did, you kind of punted on this, because you said there should be a hybrid. So, what kind? And so I think, really, we should tell -- this is an area that needs to be developed while we're working on the benchmarking and the risk-adjusting, and that can only be done if we get started, and to me limited scale means small number of sites where you learn these parameters.

CHAIR BAILET: Kavita.

DR. PATEL: I swung from 2 to 4 simply to skew the vote.

[Laughter.]

CHAIR BAILET: You're a strategic voter.

DR. PATEL: I 100 percent did it, like I did yesterday, to weight it so that no matter what, which is telling you the problem with the categories.

But having said that I see three issues. Number one, I accept that as a PRT I think we're still struggling, even though we're doing a better job on the PRTs, with how to not feel like we're rewriting the proposal for them.

But I agree that we should have just probably declared, especially to the PTAC, this is what we think would be a better way to do this. I think we're still -- at least I feel personally.

Number two, we probably should revisit our RFP, because it sounds like we're also sending mixed messages in that RFP that we've written. And then number three, we've had like four Secretaries since, you know, this law passed, so I wonder if we also need to have some refresh on at least what the spirit of these criteria are, to some degree that that's possible, because Grace brought -- we brought up points around access, which is not a criterion. We've brought up this, like -- and I'll just say, from my past legislative experience I've seen this happen all too often with what gets written into regs and then subsequent administrations and people have varying different interpretations of it, and we end up being very rigid when we don't need to be.

CHAIR BAILET: Bob.

DR. BERENSON: So I kept my vote at 3, and everything has mostly been said. I would like us to say something about payment. My preference would be at least to express concerns. We don't have to say it's a non-starter to have substantial financial risk in a population

in whom a substantial number will die within the period of the project. I think this is just a very different population than an ACO population, and that uniqueness raises some real concerns that I would want to see much greater clarity on the accountability side between the primary care physician and this very positive intervention that's going to be happening.

So I don't know that we have to force a vote -- does everybody want to vote for or against Option 2. I just think we want to identify some concerns about the shared savings model. Perhaps they can be worked out. Perhaps there's a way to provide the necessary protections for the beneficiary. So I would just want to have that sort of listed as a concern.

CHAIR BAILET: So it's Bruce, Harold, and then Len.

MR. STEINWALD: So I would like to understand better why you believe that in a population where death is a high probability it is incompatible with shared savings. Do you believe that the payment system -- that death is not really an independent event and the shared savings may influence the death rate?

DR. BERENSON: Absolutely. The decision about advanced care planning, whether you're going to be

resuscitated, whether you're going to be referred to the hospital if you have dementia, and there's a real issue around whether you want life-saving treatment in a hospital or just be allowed to die in the nursing home. That's what I'm talking about. I think it's a huge difference in this population.

CHAIR BAILET: Harold.

MR. MILLER: I personally think the shared savings model should be outlawed. I think that they are bad in all respects, and I would be happy to regale you with all the reasons for that here, but I will not, in the interest of time. However, I think they are particularly bad in this kind of a population. I agree with Bob wholeheartedly about that. The very cheapest patient of all is the patient who dies, and any patient who is at risk of death is, in fact, that is a serious, serious, serious problem. And I don't think we should be doing anything to encourage it and I think it is unfortunate that the notion that the answer to everything is a shared savings model is a big problem nationally.

CHAIR BAILET: Len.

DR. NICHOLS: Well, now I feel compelled to make a longer speech. But I was just going to say that Sarah passed me a note, which I agreed in the middle of all of

this that, you know, this conversation we just had is connected to the conversation we had yesterday about palliative care and advanced care planning, and in particular, the discussion of how people on the ground, in the real world, even with great professional support, are not ready, I believe was the phrase I heard. Not all of them are ready to have this conversation. We need to work on that. And I would say, in the letter to the Secretary, we need to think about getting some of the insights of the palliative care world in this world, together with CMS, to work out the parameters of how to do --

Harold, I know your thing about shared savings. What I'm talking about is there can certainly be an open-ended incentive that is different than the per capita model that the first model is, that more greatly incentivizes, I'll just say "flexibility," because that's the word they used, and I don't think we are incapable of working it out, in a way.

I will say, by the way, death is not necessarily the cheapest patient, because you can spend a hell of a lot of money doing heroic stuff before they die --

MR. MILLER: I should have said --

DR. NICHOLS: -- versus --

MR. MILLER: -- dying quickly.

DR. NICHOLS: Could I finish? Okay. Because that's very different than what you said, and that is very important. That's the whole point of the palliative care movement.

So I really do think we could make both models work, and I don't think we should tell the Secretary you can't.

CHAIR BAILET: So, Tim, do you want to make a comment? Okay.

DR. FERRIS: On the same topic. So I really, seriously appreciated their effort, not to be too heavy-handed and overly regulatory. I think because of the issues that Bob pointed out, and we were just talking about, I actually do think -- and this is just for the sort of recommendation to the Secretary, and I don't think this requires a vote -- but I think in this situation, actually mandating that in a payment arrangement like this that there be a goals of care documented and available to the person on call. It should just be a baseline requirement. They do it because they're terrific and they do great care. We have to think about a payment model for anyone who signs up for it. I actually think that should be an --

CHAIR BAILET: I support that.

DR. FERRIS: -- an absolute requirement, for all

the reasons that we talked about.

CHAIR BAILET: So is that sufficient?

MS. STAHLMAN: [Nods affirmatively.]

CHAIR BAILET: It is? Okay. Thank you, Tim.

DR. FERRIS: And the other one was -- I mean, I guess I'm already on record as saying all the other ones. But I do think an issue around scalability and the restriction to a geriatrician, I don't get that. Like the vast majority of nursing home patients in the United States are actually cared for by internists. A lot of internists I know have become geriatricians, although are not board-certified, and then family practitioners the same way.

And so I'm not sure that particular element of it was particularly convincing to me, and I just wanted that to be part of the recommendation.

CHAIR BAILET: Bob.

DR. BERENSON: Yeah, on this point, Independence at Home was drafted by geriatricians with the idea that geriatricians would be -- and geriatric nurse practitioners would be the team. But in the real world, that hasn't happened. You do have -- some of those centers are family physicians or internists. I mean, perhaps the gold standard is a geriatric team, but I don't think that should be a requirement, if we have some entry requirements around

quality, and, you know, something like that.

So I think we should suggest some flexibility about what that team should consist of.

CHAIR BAILET: Grace.

DR. TERRELL: I agree with that, as an internist who is mostly a geriatrician these days. However, one of the points that they're making in their proposal is that there is something different and special about specialized geriatric care that may be different from what classic primary care would provide in those situations.

So one of the points that we make is that this would provide that type of expertise to a much broader portion of the population who might -- would benefit from that relative to the number that are out there. There's not a lot of geriatricians in the universe. And so as we do that language, we ought to do it in a way that actually says if it's going to be broadened there needs to be understanding of the value add for those that have gone through the extra training and expertise relative to what the value add would be to broadening those who could participate in the model, because I think that the geriatricians would say that their value add is more than just what classic internal medicine training or family physician training does, even though many of us have

essentially become that over time.

CHAIR BAILET: Thank you, Grace. Again, I want to express our gratitude for Avera Health and for fielding a very important model.

Oh, Sarah. Wait a minute.

MS. SELENICH: I just have a few clarifying questions if that's okay.

So I think that it's clear that you've identified a number of issues but that you think there are fixes that can be done pretty quickly. One of the questions I have, the PRT, and as you all discussed, had a number of concerns about the quality measures. I know, Tim, you decided specifically that this care plan needs to be a requirement, but not necessarily a quality measure, just a requirement of the program.

But in terms of sufficiency of the measure set, could you all expand maybe a little bit on that. Is that something that still needs a lot of work? For example, Tim talked a lot about emergency department visits and admissions maybe needing to be a necessary part of that, but I don't know if you were persuaded by the submitters' comments.

CHAIR BAILET: Tim.

DR. FERRIS: I guess from my perspective a couple

of things.

I think someone has to think through the implications of a payment model that uses the denominators that are in the ones they suggested. I think that -- and so there's some work that needs to be done. I suspect, and maybe it's only because of familiarity, that a rate per thousand on those events is more useful as a measure than a rate per facility. And I just -- but I'm confused about that because I just haven't -- like when you have multiple facilities, how does that work?

So I think there is some thinking that needs to be done. I don't think it's -- when I look at the measure set itself, the numerator statements and what it is the conceptual, those are the right things to be measuring. They're great measures. So it's more the technical aspects of measurement and how to include those in a formal way. That's work that someone at CMS would need to do anyway, in building a model. So that would be my --

And I do actually think, and I don't know if this group agrees, and I said this but a little more cryptically in my comments about my vote, that I think I prefer Model 1, but that the accountability in Model 1 needs to be improved. The way I specifically would go after that, and just a suggestion, is in ED and admission rate per

thousand, which could, in the first year -- this is the way all the other ACO quality measures were done -- the first year was a pay-for-reporting. They got all the data necessary to do the benchmarking in the first year and then they implemented it as pay-for-performance in the subsequent years.

So I would say those would be my thoughts about the quality measures.

DR. NICHOLS: Could I just ask, when you say focus on ED and admissions, that, to me, is implicitly weighting them higher than the other nine. So, I mean, that's part of the conversation here, right?

DR. FERRIS: Yeah, the --

DR. NICHOLS: You're elevating them to the --

DR. FERRIS: -- the proposal said -- used a -- and I'm not going to get the right, but like four out of six or something like that. I would say, for me, to feel comfortable with the accountability in number one I would want to see that as a mandatory, like that's not a one of six. I'm sorry. That's great. It's not an option. Like you have to report it and then you subsequently have to perform in it in an achievement attainment model.

I mean, I don't want to do the work. None of us want to do the work here, but that would be sort of the

most obvious way to thread that needle.

CHAIR BAILET: Kavita.

DR. PATEL: Just to help answer Sarah's question, it's cross-walking what the submitter used, which is based on -- and I just verified it to double check -- which is based on Nursing Home Compare, which is done at a facility level, and they, in some of their metrics, do use the resident census. It's getting at this, you know, kind of -- their unit of analysis ends of being a facility so that they could generate Nursing Home Compare quality measures.

So I would just say that we would recommend using more standardized denominators such as resident census or bed days, or something more appropriate for larger standardization. That's all.

MS. SELENICH: Okay. Thanks. And then just one other --

MR. MILLER: Can I just add one other thing?

MS. SELENICH: Yes.

MR. MILLER: I think this is consistent with Tim's second point, but just clarify. Say so if it's not. I think, to me, the issue is there's sort of a blur of some utilization and quality measures together, and it is typical to think about, since this is the requirement is that the program has to either save money or improve

quality and not spend more money, et cetera. So to sort of blur them together and say you can do well on a mix of them and it's okay is not really consistent with the notion of an alternative payment model.

So, to me, the issue is there needs to be some separate focus on the utilization measures, which, as opposed to having shared savings model -- in fact, Medicare, in the CPC+ model, said we're not going to do shared savings anymore. We're going to focus on utilization measures that primary care -- we think primary care practices can manage. So the same sense here.

But there's two separate pieces. There's a utilization and then there's a quality, and you have to think about how they interact. But I think that, to me, is kind of what was missing here was you sort of -- as long as you did okay on a number of the measures it was okay and there was no distinction between the utilization and the quality.

DR. FERRIS: I completely agree. Thank you, Harold, for that friendly amendment.

CHAIR BAILET: Sarah.

MS. SELENICH: Okay. The last thing I just wanted to raise, in terms of summarizing your feelings about the two payment options, I heard, you know, from the

PRT that they maybe would have liked a hybrid option or a middle-of-the-road option, at least initially. Some of you are in favor of trying out both options, and then I heard some of you say that you agreed kind of starting with a simpler model might be preferable.

And so I was going to sort of reflect those varying opinions in the report, and then also -- but talk about some of the strengths and weaknesses as identified by the PRT and here. I just wanted to make sure that that was the approach, or if some of you were really leaning for let's vote on we think payment option 1 is the right option to start with.

CHAIR BAILET: Harold.

MR. MILLER: So I'll say what I think and then see if anybody else agrees with it. But to me, the issue of one or two models, or whatever model, is the issue of whether everybody can participate in one even hybrid model. So the applicant basically, whenever they said a performance-based payment, they said we think that this might be more feasible for smaller practices, et cetera.

So to me, it would be better, simpler all around if you just had one approach. The only thing I would say is if it turns out that you can't -- don't think you can design an approach that works well for everybody, then

there may need to be two approaches. But that's how I think about it. It's not should we have two models for the sake of having two models because we can't decide. I would rather say we have two models because we think that we need to have -- and I was suggesting earlier it may be the same model, but there might need to be some special help for certain practices to get started or whatever, which has been done in ACO programs. At least that's how I'm thinking about it.

CHAIR BAILET: Bob.

DR. BERENSON: Yeah, I wouldn't mind saying that there was something of a preference difference between those who would start with simple and those who would want us to do hybrid. I don't have a strong feeling about that. If we say we could go either way with that, but we have concerns that would have to be addressed, and then list those concerns that would have to be addressed about both payment models, I don't think we have to have a strong opinion about which route to go, I guess is what I would say. So reflect different -- we had some different views, but what we agreed on were the following concerns, something like that.

CHAIR BAILET: Len.

DR. NICHOLS: I think you had it right before we

started talking. I think there are three views here, and I think you should reflect them, and add the caveats. But there are three views.

CHAIR BAILET: Seeing agreement, Sarah, are you good or you want to just keep -- you're good? Okay. Very good.

All right. So I was actually using my best stuff in thanking these guys when I got thrown off my game, but, again, this is important. The country -- the country needs it. I think as physicians and clinicians who are listening in, we've all been in skilled nursing facilities and nursing homes where it's -- there's opportunity for improvement. I think the comment about supporting the nursing staff and the other staff supporting these patients, having this as a backstop is incredibly important. And I think that that point was -- it was made, but I think it's worth reemphasizing, that it does -- having this available does improve the quality of the staff because they're able to hold on to really good people.

Again, I really appreciate all of the engagement from the Committee. I think we're going to -- unless there's something else, again, thank you, Mary Ellen. It's been a good -- been a rich two days, and I think I just again want to thank everybody for their attention and

engagement.

We're going to adjourn.

* [Whereupon, at 11:50 a.m., the Committee was adjourned.]